# Report on Effective Psychotherapy:

## LEGISLATIVE TESTIMONY

by

Roberta Russell

# REPORT ON EFFECTIVE PSYCHOTHERAPY: LEGISLATIVE TESTIMONY

**by Roberta Russell**

The warrior who receives mysteries must claim knowledge as power. We choose either to be warriors or ordinary men. A second choice does not exist on this earth.... An impeccable stalker can turn anything into prey.... We can even stalk our own weaknesses. But stalking your own weaknesses is not enough to drop them. You can stalk them from now till doomsday and it won't make a bit of difference. What a warrior really needs in order to be an impeccable stalker is to have a purpose."

--Carlos Castanada, 1977

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by Roberta Russell



originally
Published by Hillgarth Press
PO Box 1440 Lake Placid, NY 12946

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ISBN 0940106 54 X
Printed in the United States of America

ACKNOWLEDGMENTS

This report had its formal genesis in the teaching of Arnold Bernstein, my guide, who has always supported my desire to know and provided an arena for my growth. He connected me to the beauty of psychoanalytical thought and to such brilliant thinkers as Thomas Szasz, M.D., R. D. Laing, M.D., and Erving Goffman, Ph.D., all of whom led me on to further exploration in the field.

I wish to thank Peter Ross, Ph.D., who gave form to the report and added the rigors of scientific methodology, and Professor Howard Latin for his critical scrutiny.

I am grateful to the distinguished members of the psychotherapeutic community cited here who welcomed my queries in a spirit of mutual inquiry and shared their knowledge freely, especially Daniel Hogan, J.D., for his openness, intellectual integrity, and generosity with his wealth of knowledge; Robert Carkhuff, Ph.D., Arnold Lazarus, Ph.D., Hans Strupp, Ph.D., Alan Towbin, Ph.D., and Irving Weinstein.

I am particularly grateful to Suzanne Smith, whose careful editing and moral support carried this report to fruition. I would also like to thank Professor Fred Supnick, K. U. Smith, Ph.D., and Cheryl Haley for their professional input, and Janabell Rubinstein for her efforts above-and-beyond in the final production stage.

Most of all, I am indebted to my father, Frank Ottenstein, for teaching me how to think.

R.R.
March, 1981
New York

TABLE OF CONTENTS

## Section One

REPORT ON EFFECTIVE PSYCHOTHERAPY

by Roberta Russell

### Origins, Purpose and History of the Report

My lifelong quest for an understanding of why people do things was formalized in 1979 when I was elected to take charge of a fact finding committee of NAAP, an American psychoanalytic accrediting body. As a public member, I was asked to explore the research on "what works" in psychotherapy and make recommendations in the interest of protecting the public, the consumers of psychotherapy. In March, 1980, I presented my findings to NAAP.

The purpose of this report was to seek out the common denominator of the "active ingredients" in the therapy process. The study was undertaken with no particular allegiance to any school of thought. My intent was to

take a relatively unbiased look at the research done on therapy outcome—and perhaps a more biased exploration of some professionals I thought to be seminal thinkers in the therapy enterprise. I also interviewed professional therapists representative of the profession to gain perspective on what seemed at first to be rather strange research conclusions.

In 1980 my report on effective psychotherapy research was incorporated by Mary Harvey, Ph.D., of the National Center for the Study of the Professions in Washington, D. C., as input for a grant proposal formed at the Social Action Research Center in San Rafael, California. Since that time, it has been presented by invitation to various organizations and schools in Europe.

In Geneva, Switzerland, the European Association of Humanistic Psychology invited me to be an honorary member of the board after hearing this report and asked me to submit it to the World Health Organization with them. After reading a summary of this report, a top official at WHO suggested that EAHP consider an official alliance with them. Subsequently, I was invited to give this talk in Zaragosa, Spain at a conference on the future of psychotherapy. The report

was once again received with enthusiasm. K. U. Smith, prolific researcher, author and professor emeritus at the University of Wisconsin, said that this report had the potential to become "the first book to give consumers, teachers and organizations an idea of the real meaning of psychotherapy."

I was then asked to speak at a conference given by the Italian Association of Humanistic Psychology, at which R. D. Laing was also a presenter. His conclusions were not unlike my own, although they were born of experience, not research. I was then called upon to speak at the Sophia University of Rome. Both Italian organizations will publish a summary of this report.

Most recently, the substance of the report was submitted as legislative testimony at a public hearing on the subject of "The Regulation of Mental Health Practitioners," conducted at The City University of New York on March 5, 1981, by Assemblyman Mark Alan Siegel of the New York State Assembly Committee on Higher Education. It is scheduled to be presented to the National Advisory Council on Mental Health Delivery in April.

## Section Two

## THE METHODOLOGY

Why has this report attracted attention? There are volumes of research on the effectiveness of psychotherapy. What is different about this study?

This investigation asks a central question: What makes people grow?

The methods of investigation combined a variety of techniques:

- A general review of the therapy outcome literature.
- Extensive examination of exemplary studies.
- Interviews with seminal thinkers or those psychologists whose particular experience enabled them to shed light on conclusions which seemed enigmatic in the context of formal therapeutic doctrines.

It is structured to mobilize people to improve their human interface systems. To this end, it includes:

- Six research findings followed by an explanation and supporting evidence for the individual points at issue.
- Suggestions for ways in which we, at this juncture, can become change agents.

- An exploration of the conditions which foster therapeutic growth.
- An extensive list of references.
- A workbook designed to actualize effective psychotherapy.
- Specific recommendations to improve the therapy endeavor.

Although research in the behavioral sciences has frequently been inconclusive in the past, there has been a marked trend toward increased sophistication of experimental design and rigor (Gurman and Razin, 1977). Using this new research as a base, this report is formulated to stimulate further thought and exploration.

## Section Three

## PRELIMINARY RESEARCH FINDINGS

The six preliminary research findings and key sources of supporting evidence are:

1. Comparative studies show that the outcome of psychotherapy does not depend upon the school to which the therapist adheres.

   (Bergin & Suinn, 1975; Frank, 1973, 1979; Garfield & Bergin, 1978; Gurman & Razin, 1977, Hogan, 1979, Luborsky, Singer & Luborsky, 1975; Meltzoff & Kornreich, 1970; Sloane, Staples, Christol, Yorkton & Whipple, 1975; Smith & Glass, 1977; Strupp, 1979a, 1979b; Truax & Carkhuff, 1967)

2. Experienced therapists are generally more effective than inexperienced therapists.

   (Gurman & Razin, 1977)

   The common denominator of experience makes experienced therapists resemble each other to a greater extent than they resemble less experienced therapists trained in their respective disciplines.

   (Fiedler, 1950a, 1950b; Garfield & Bergin, 1978; Gurman & Razin, 1977)

3. Paraprofessionals consistently achieve outcome equal to or better than professional outcomes.

   (Carkhuff, 1969; Durlack, 1979; Gurman & Razin, 1977, Hogan, 1979; Strupp, 1979a, 1979b; Tennov, 1978)

4. A professional training analysis does not appear to increase the effectiveness of the therapist.

   (Garfield, 1979; Garfield & Bergin, 1978; Hogan, 1979; Gurman & Razin, 1977; Marmor, 1979; Meltzoff & Kornreich, 1970)

5. Therapists who have undergone traditional training are no more effective than those who have not.

   (Henry, Sims & Spray, 1971; Hogan, 1979; Rogers, 1973)

   Microcounseling and skills training appear to be useful procedures in the training of therapists.

   (Carkhuff, 1969, 1976; Garfield, 1979; Garfield & Bergin, 1978; Guerney, 1971; Gurman & Razin, 1977)

6. Congruent matching of therapist and patient increases the effectiveness of therapy.

   (Bergin, 1979; Carkhuff, 1969; Garfield & Bergin, 1978; Gurman & Razin, 1977; Hogan, 1979; Luborsky, 1979)

## Section Four

# REPORT ON EFFECTIVE PSYCHOTHERAPY

## EFFECT OF SCHOOL OR ORIENTATION OF THE THERAPIST ON THERAPEUTIC OUTCOME

In 1977, Gurman and Razin published their highly regarded synthesis of empirical research on therapy, Effective Psychotherapy: A Handbook of Research. They concluded that we have moved from the notion that technique is the key to change to the notion that personal and relationship factors are the more powerful ingredients in the therapy process.

Comparative studies do not reveal substantive differences in the cumulative results--the client/patient outcome --of the diverse schools of psychotherapy. No discipline, no school of thought can point to a performance record that surpasses any of the others' across the board.

It is important to view this startling conclusion in historical perspective. Many leaders who have been in the vanguard of formal psychological thinking have expressed doubts about the efficacy of therapy. According to Karl Pribram, Freud himself thought that the results of psychotherapy were poor. However, he did not want his views generally known because he valued psychoanalysis as a

research tool.* Dr. O. Hobart Mowrer, former President of the American Psychological Association, has been quoted as saying that psychotherapy does not do much good.

The consensus of researchers today is reassuring on that point. The bottom line that emerges in modern studies is that some therapy is preferable to no therapy. Most therapy effects beneficial changes, and each therapy by itself can be shown to have significant effects, compared to no treatment (Gurman and Razin, 1977; Smith and Glass, 1977).

## Role of Research

In the face of this evidence, why do allegiances to particular schools of psychotherapy still dominate the therapeutic community? Part of the answer lies in the reluctance of practitioners in the field to consult the research.

As long ago as the 1950's, F. E. Fiedler was conducting courageous pioneer research on the impact of "school" or orientation on the practices and attitudes of therapists (Meltzoff and Kornreich, 1970). He asked the question (1950a): Are the differences in therapeutic schools semantic

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* Personal communication, 1980.

or do they represent actual differences in the goals the therapists set for themselves? To find out, Fiedler set up a questionnaire which required the therapists to use the same vocabulary in describing their work. The result was that the expert therapists' descriptions of the ideal therapeutic relationship were more in accord with each other than with the descriptions given by the less expert therapists within their own schools. This suggests that all therapists attempt to create a relationship that is essentially the same from school to school. The critical measure that differentiated experts from nonexperts was the therapist's ability to understand and communicate with the patient. Experts had a greater ability to maintain emotional distance.

Fiedler (1950b) also explored the relationship of the therapist to client/patient in diverse schools of thought: psychoanalytic, nondirective, and Adlerian. Using one therapy hour with the patient as the basic unit of study, he explored the therapist's feelings toward patients and the effect these feelings had on the therapeutic climate. The data was culled from 23 statements which differentiated therapists along school lines.

Fiedler found that the therapeutic relationships created by expert psychotherapists of each of the three

schools resemble (1) the ideal therapeutic relationship and (2) the therapeutic relationships established by other experts, more closely than do the relationships created by non-experts within the identical schools. Differences between schools were most clearly apparent in the status which the therapists assumed with their patients. The Adlerians and psychoanalysts tended to be more tutorial than the nondirective therapists. The study did not examine the efficacy of the various schools.

Because Fiedler's studies were unsophisticated in design, practicing psychotherapists found them easy to dismiss. However, the new research methodologies in existence today command the attention of policy-making senior professionals who sit on boards and determine accrediting procedures. Unfortunately, many of these policy makers have not had a substantive exposure to research since their training days. They are not aware that studies are frequently more "natural," less contrived, that they use actual clients/patients, and employ extensive follow-up and multiple measures of outcome. These exemplary modern works are often not available in the libraries of training institutes. What are these august bodies missing?

Study of Studies

Since the 1950's, there have been about 20 reviews of the literature on the effectiveness of psychotherapy (Hogan, 1979). The most sophisticated--and generally regarded as the most brilliant--is the "Meta-analysis" by Smith and Glass which came out in 1977.* This study is a statistical analysis which combines the findings of a large collection of results from individual studies into an integrated construct.

A good part of its authority lies in its unique approach: Smith and Glass took a larger view than previous reviewers in several respects. They found validity in both the best- and worst-designed studies, whereas most reviewers eliminate poorly designed studies from consideration. (For example, their statistics showed that studies using control groups had the same effects as studies using more casual control selection.) They criticized other reviewers' tendency to favor studies employing large samples, even when the findings of these studies are relatively weak and non-definitive.

In addition, the number of studies used lends weight to

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* Reviewed in an expanded version by the Office of Technology Assessment of the Congress of the U.S., October, 1980, in the series, The Implications of Cost-Effectiveness Analysis of Medical Technology, Background #3, "The Efficacy and Cost-Effectiveness of Psychotherapy."

the Smith and Glass review. They sorted through almost 1,000 studies to cull out 375 which represented 10 different schools of thought, including Freudian-like therapy. They created a common denominator which they called the "effect size," the mean difference between treated and control groups divided by the standard deviation. When they made allowance for such factors as duration and timing of follow-up measurements for the various studies, they came to very provocative conclusions: Despite the fact that whole libraries could be filled with volumes on the differences between therapies, Smith and Glass could find no evidence that one school was more effective than any other, when results were summed up.

This backs up the findings of an earlier comparison of behavior therapy with psychoanalytic therapy by Bergin and Suinn (1975). The authors found no difference between the two disciplines' effect on a target symptom and concluded that any existing differences are not great.

Also in 1975, Luborsky et al. published a review of 33 studies of effective psychotherapy appropriately titled, "Comparative Studies of Psychotherapies: Is It True That Everyone Has Won and All Must Have Prizes?" The researchers noted a marked similarity in degree of effectiveness among

the major therapies, regardless of theoretical orientation, which they ascribed to relationship factors.

Behaviorist vs. Psychoanalyst: Elusive Differences

In that same year, Sloane et al.(1975) published an important study on behavior therapy vs. psychoanalytically oriented therapy, which also confirmed that both types of therapy work equally well, although in theory behaviorists attempt to change behavior and psychoanalysts attempt to change ideas. In addition, Sloane's group pointed out considerable overlap in the techniques of the two groups. Both take detailed histories, and both try to formulate the patient's problems, the etiology of the problems, and the forces that support the patient's maladaptive behavior. Both correct misconceptions, define objectives, and make use of abreaction (cathartic emotional release) and suggestion. Further, the Sloane team found that many of the differences between the schools are a matter of degree rather than substance, e.g. the behaviorists tend to be more concerned with symptoms and less with childhood memories than the psychoanalysts. On the other hand, although the behaviorists in the experiment were more active and directive, it surprised the authors to find that they made about the same number of

interpretive statements as the psychoanalysts. In practice, the contrast between the behavior of the two groups of therapists is elusive.

The patients who had achieved success in this study attributed the outcome to the same factors: a good relationship with the therapist; the therapist's ability to generate insight; the value of confronting problems; and the trust developed by talking to an understanding person. The conclusion of this seminal study is that "the temple of truth may be approached by different pathways."

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"Every method and school of psychotherapy is actually a system of applied ethics couched in the idiom of treatment, and each reflects the personality, values, and aspirations of its founder."

Thomas Szasz, Heresies, 1976

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Four years earlier, in 1971, Henry et al. had sought to find out whether the techniques of practitioners correspond with the techniques they were taught in training. After a survey of over 200 practitioners, the authors concluded that the individual psychotherapist does not rely on any single

basic technique. They also concluded that there is considerable similarity among the methods of professionals of widely differing persuasions and that therapeutic ideology does not affect the actual behavior of traditional psychotherapists.

Gurman and Razin (1977) carried this thought one step further. They concluded that the differences among therapists are more evident in how they think than in how they or their patients behave.

Summary

Therapists behave similarly in many respects and are often influenced by the particular client with whom they are interacting, even though the rationales they give themselves, their patients, and their colleagues may be dissimilar. In other respects, therapists behave dissimilarly in ways that are consonant with their orientation. However, therapists continue to muddy the waters by talking one game and playing another. Many of the advertised contrasts between therapists of various persuasions are just that: advertised, not practiced.

## EXPERIENCED THERAPISTS ARE MORE EFFECTIVE THAN INEXPERIENCED THERAPISTS

If theoretical orientation is the major determinant in therapy, we would expect therapists of one school to differ greatly from those of other schools. If, on the other hand, there is a concept of the ideal therapeutic relationship which springs from natural skill born of personal experience --and if a specific type of relationship has been found to be maximally effective--then we would expect expert practitioners to have more commonality among themselves, regardless of school, than they have with less expert therapists within their own school.

### What is an Expert?

According to Gurman and Razin (1977) experienced therapists resemble each other in that they are, as a class, more effective than inexperienced therapists. Of course, there are individual exceptions to this clear trend. However, in the main, experienced therapists take more initiative and are more congruent. They are also less optimistic in their expectations and therefore more realistic. When they itemized the operative elements in their individual approaches, experienced therapists rated themselves as more patient, more interested in history, more willing to wait for information, more

interpretive, more variable in interview behavior, and more effectively expressive than inexperienced therapists.

What do Patients Prefer?

As early as 1960, in an investigation of therapeutic style, Lennard and Bernstein compared client/patient evaluations of interviews which flowed easily with interviews rated as difficult. Clients/patients preferred therapy sessions with an active, emotionally expressive therapist who avoided a high level of interrogation and ambiguity. The investigators concluded that therapy's most important contribution lies in the total recurring pattern of patient-therapist interaction. Similarity in therapeutic practice suggested to them that what is shared by different patient-therapist pairs may be at least as therapeutic as what is unique. They also found that feedback plays an essential role in treatment.

If experienced therapists tend to achieve better results than inexperienced therapists, and therapists from divergent schools become more like each other than like inexperienced therapists of their own discipline, it follows that therapists must be learning what works as they progress. What potent universal factors are producing change and working to overcome the differences emphasized by specific schools?

Six therapists were interviewed in the quest for the

answer to this question, and they provided illuminating replies.

"What makes people grow?" I asked them.

... Arnold Lazarus

Arnold Lazarus is a prominent multimodal therapist, a professor of psychology at Rutgers University, and author of numerous books. He said simply that performance-based measures were the key to growth. He was adamant in his imperative to the therapist: the client must be persuaded to practice new behaviors. The performance of new, desired behaviors is the cause of change; insight-based therapies are useless. However, further questioning led us to other territory.

Q: "Are you so powerful a person--do you come so highly regarded--that clients just walk in, you analyze their difficulty, give them homework assignments, and off they go?"

A: "No, some patients take a year of corrective emotional experience before they can try any new performance-based measures."

Q: "Might this delay period--before the client is able to go out and practice new behaviors--be what the Freudians refer to as transference?"

A: "I suppose it is."

In a word, the way therapists talk about what they do seems to correlate with their school of thought, but not with their actual behavior.

... Irving Weinstein

Irving Weinstein is a successful New York eclectic psychologist who has been practicing for more than 20 years. Queried about the therapy process, he described it as a parenting process. He recalled instances when he had extended himself personally to make a client/patient feel cared for and achieved rewarding results. He did not raise the issues of performance-based measures or behaviors, which were so central to Lazarus' concept of therapy, but he replied, "Oh, sure," without hesitation when asked if he gave client/patients behaviors to practice. "I tell them to go get the New York Times and look at the job listings if they are afraid of looking for a job." In effect, Weinstein gave patients successive tasks to do until the desired behavior was approximated.

What is the difference between the approaches of these two therapists? Substantively there are more similarities than their initial descriptions indicate.

... Robert Carkhuff

Robert R. Carkhuff is the fifth most-quoted man in clinical psychology, according to the Social Science Index.

A noted psychologist and author of more than 50 books, he has done research with Carl R. Rogers and developed the frequently cited Carkhuff-Truax Empathy Scale. He believes that therapy is generally implemented in a vague fashion and that therapists need to master some substantive skills. It is Carkhuff's view that the therapist has to provide not only responsive conditions, such as empathy, understanding, respect, and specificity of expression, but also initiative dimensions, such as genuineness, confrontation, and interpretations of immediacy. When interviewed, he expressed concern that psychologists fall somewhat short on the management end and that they would profit from learning to use performance-based measures.

... Alan Towbin

The career of Alan Towbin, a psychologist, researcher, and teacher based in New Haven, Connecticut, led him to work with patients in the most neglected wards of a mental hospital. Although all of these inmates had been in the "back" wards for over three years, Towbin organized them to work as a team, and within six months they all accomplished their initial goal, living and working in the community. Now, several years later, he confided that they are still carrying on productive lives outside the institution. He expressed his views in an article titled "The Confiding Relationship: A New Paradigm." Therapy,

for Towbin, is basically being a confidant. Utilizing the skills to listen, to be warm and supportive, and to be honest can make people grow.

... Daniel Hogan

In 1979, Daniel Hogan, a Harvard-based attorney-therapist, published four scholarly volumes called The Regulation of Psychotherapists. They constitute a comprehensive review of research on effective psychotherapy, as well as a legal history of court disputes involving the regulation of psychotherapists. In this authoritative work Hogan identified empathy as the most important ingredient in effective psychotherapy.

... Hans Strupp

Hans Strupp is also one of the leading researchers in the field of psychotherapy. His Vanderbilt study (1979) is regarded as a classic and powerful work. Strupp thinks that growth is promoted by nonspecific factors such as understanding, trust, and warmth, which are not the exclusive province of any single therapeutic school of thought. By and large, he feels that all prominent therapeutic approaches have been shown to be equally effective. Although they may not all be alike, there is no proof that one is better than the other. Strupp said, "The art of psychotherapy may consist largely

of judicious and sensitive applications of a given technique, delicate decisions on when to press a point or when to be patient, when to be warm and understanding or when to be remote. The therapist structures the situation in bold relief so that the patient is forced to renounce the helping relationship or undergo change" (Gurman & Razin, 1977).

The formal title of Strupp's Vanderbilt study is "Specific versus Nonspecific Factors in Psychotherapy: A Controlled Study of Outcome." It links the therapist's technical skills and the qualities inherent in a good human relationship to outcome in time-limited individual psychotherapy. In this study, Strupp worked with male college students who exhibited high levels of depression, anxiety, and social introversion, as measured by the Minnesota Multiphasic Personality Inventory. One group of 15 was treated by highly experienced psychotherapists. Another group of depressed, obsessional, anxious men was treated by "nice guy" college professors chosen for their ability to form understanding relationships.

Each student participated in therapy sessions once or twice a week over a period of three to four months for a total of 25 hours each. Each session was audiotaped, and some sessions were also videotaped. Strupp used multiple

measures of assessment, such as patient, clinician, and therapist ratings of fundamental change, change in MMPI scores, and change in specific target complaints. In addition, he followed up one year later, when the initial gains shown in many studies have long since dissipated. The results of this investigation were consistent and straightforward. On the average, the patients who consulted with college professors showed as much improvement as the patients treated by experienced professional psychotherapists. The greatest degree of change occurred during the treatment period, but the behavior was maintained at the time of the follow-up assessment one year after intake. The experimenters concluded that positive change was generally attributable to the healing effects of a benign human relationship.

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"The cure of the soul has to be effected by the use of certain charms, and these charms are fair words."
-- Socrates, from Thomas Szasz, 1979

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Jerome Frank (1973, 1979) believes that the effective factors are the same for all therapies. He suggests that the therapist's personal qualities are the powerful factors and

that techniques merely provide the ritual by which these personal influences are mediated. In other words, technique is critical only insofar as it provides a believable rationale for the change agent. Frank contends that most symptoms are related to demoralization, which can be alleviated by the discovery that others have the same problems. He calls this "universalization." The therapeutic relationship then restores the patient's hope, and it is primarily the ability to engender hope that effects change.

The formidable Thomas Szasz has a similar orientation. He believes that symptoms are the language of helplessness. In his view the problem for the therapist is demoralization.

What constitutes a benign human relationship that builds morale and provides a successful experience for the client/patient?

Frank (1973, 1979) defines a therapeutic relationship as an intense, emotionally charged, confiding relationship, often with the participation of a group, and this belief is shared by many therapists. He describes the interaction as a process which begins with the therapist's acceptance of the client/patient self-revelations. This combats the client/patient sense of isolation and paves the way for trust in the therapist, because the patient senses good

will and a healing setting. In the next stage, the therapist's personal qualities begin to have an impact, and his ability to establish a therapeutic alliance undergoes testing. At this point, the healing setting reinforces the relationship, and its symbols define the office as a place of healing. Frank calls this an "edifice complex," reliance on a safe place.

The six active ingredients in therapy, according to Frank, are:

(1) A shared belief system, which creates a bond between the patient and the therapist and gives them something to do together.

(2) A ritual and myth which maintain the patient's hope and promote symptom relief.

This thesis was tested in an experiment with three groups of patients who underwent therapy on different schedules. One group had the minimum, a half hour every two weeks, one had a half hour per week, and the other had an hour per week. After six months all three groups demonstrated the same degree of symptom relief. Frank concluded that the act of beginning therapy induces symptom reduction because it makes the client hopeful.

This concept led him to experiment with placebo research, using inert medications. Clients were given a symptom checklist and told, truthfully, "We know this medicine will help you as it has helped so many others." After a half hour the experimenter again tested for the symptoms and found a decrease which matched the drop after six months in therapy. The curves were identical. Surprisingly, most of the drop occurred before the pills were administered. It appeared that the tests, coupled with the positive expectation, produced the symptom relief. Frank reports that positive response to a placebo is not a consistent trait, but everyone is prone to such a reaction some of the time.

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"Fortis imaginato generat causam."
"A strong imagination generates the actual event."

--Arnold Lazarus, In the Mind's Eye, 1978

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Expectation is a phenomenon which influences behavior, whether it is in the form of myth, placebo, or structured role. Frank also reported a study which anticipated the

advantage of positive expectation. Researchers conducted 20-minute role-induction interviews with each client, stating what might be expected from the therapist, what techniques were going to be used. Given the advantage of role induction, the patients lived up to expectations and achieved better outcomes than the control group. These findings have been replicated. They make a strong case for a correlation between expectation of process and patient improvement.

(3) Opportunities for cognitive and experiential learning through the acquisition of new data linking present problems to past life experiences. It is possible for a patient to gain this insight by using friends as therapists or group members as models.

(4) Emotional arousal to provide thrust for the insight. Freud used the term "abreaction," but by any name emotional arousal appears to give impetus to the therapeutic process. It increases the patient's dependence on the therapist. It breaks up old patterns and furnishes the incentive to form new ones. Frank demonstrated this point by giving some patients whiffs of ether. He found that transitory attitude shifts could be effected in this experimental group more easily than in the control groups.

(5) A growing sense of mastery over the social environment, stemming from better insight and from the assumption of responsibility for one's own behavior. All therapies seek to bolster self-efficacy by insight and success experiences.

Naming is a technique which seems to increase the sense of mastery. Frank reports that Werner Mendel explored this phenomenon by dispensing one of six all-purpose interpretations, such as "You have to apologize all the time," or "This always happens to you with women/men." He delivered these interpretations after the first 10 minutes in each session with four patients in long-term therapy. In all, he repeated the interpretations six times to each of the four patients, a total of 24 times. He found that the patients experienced a decrease in anxiety 20 times out of the 24.

(6) Practicing what has been learned in therapy, using the structure and methods provided by the therapeutic myths and rituals.

Evidence suggests that the skills required to administer therapy improve with practice, however complex the active ingredients of the therapy are. It seems likely that this improvement stems from listening to patient feedback, which is a self-correcting process for those who are open to its influence.

## PARAPROFESSIONALS CONSISTENTLY ACHIEVE OUTCOMES EQUAL TO OR BETTER THAN PROFESSIONAL OUTCOMES

Studies comparing the effectiveness of "functional professionals," or paraprofessionals, to the effectiveness of professional therapists show with startling consistency that the nonprofessional is superior in performance. Indeed, according to Hogan (1979), corroborating evidence on the effectiveness of paraprofessional training programs is more abundant than evidence in support of professional training. Although long-term follow-up on these studies is lacking, the uniformity and pervasiveness of the results makes them worthy of investigation.

Anthony and Carkhuff (1977) defi.. functional professionals as individuals who do therapy without formal credentials. They are usually selected on the basis of relevant personality characteristics indicated by empathy scores. Although it may be sound common sense, this practice is not standardized professional selection--which may be one key to the surprising results. The college professors in the Strupp study fulfilled the selection qualifications for functional professionals because they were chosen for relevant personality characteristics.

Similarly, the speed and pertinence of the paraprofessionals' training may contribute to their success. In traditional training the student is often saddled with irrelevant procedures, but paraprofessionals start without that disadvantage. "If the only tool you have is a hammer, you tend to treat everything as if it were a nail," said Maslow (1966).

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"...With minimum intensive 'on-the-job' training...I know that in many of these crisis situations ['hot-line' workers] use a skill and judgment that would make a professional turn green with envy."

--Carl R. Rogers, American Psychologist, 1973

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Paraprofessionals are taught to use straightforward methods of treatment which de-emphasize introspection and insight. Trained in skills conducive to behavior change, they attempt to integrate the achievement of insight with the ability to put it to work. These practical approaches focus on personal interaction. They do not demand formal schooling; training is usually well under 100 hours.

In addition, paraprofessionals are spared the onus of trying to administer therapy from a detached, aloof posture. The traditional therapies' insistence that counselors reveal

themselves as little as possible prompted Sullivan (1954) to point out the following contraindication. He said, "Were any of us to be interviewed about a significant aspect of our living by a person who gave us no clues as to what he thought and how we were doing, I think we would be reduced to mutism in a matter of minutes."

Finally, some paraprofessionals enjoy the unique position of serving a client population made up of their own cultural group, e.g. college students on crisis intervention lines, racial minorities in a community. Understanding is reached faster when the therapist and client/patient have a similar background.

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"Experiments both with human children and with rhesus monkeys show what a tremendous difference to the intensity of fear responses is made by the presence or absence of a trusted companion....Yet, it is evident that, when psychologists and psychiatrists come to theorize about fear and anxiety, the significance of these phenomena is gravely underestimated."

--John Bowlby, Support innovation and autonomy (1973)

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A dramatic study by Suomi, Harlow, and McKinney (1972)

illustrates the effectiveness of untrained "therapists." This experiment needs no statistics. It is called "Monkey Psychiatrists." The clients/patients were six-month-old monkeys who had been maternally deprived from birth. These neurotic creatures alternated between cowering in corners and being inappropriately aggressive with other monkeys, in a general disregard of the social hierarchy. They were unable to exhibit sexual behavior and could not reproduce except by artificial insemination. Even then, they were hostile to their babies.

The "psychiatrists" were three-month-old monkeys who had had a normal upbringing. The two groups were exposed to each other on a regular basis. When the neurotic monkeys "acted out," the monkey doctors, who were too young to have aggressive responses, just held them. Within six months the neurotic youngsters demonstrated nearly complete recovery by exhibiting sexual behavior and reproducing. The authors conclude, "We are all aware of the existence of some therapists who seem inhuman. We find it refreshing to report the discovery of nonhumans who can be therapists."

Treatment as Training

In 1965 Carkhuff published a review of 80 articles in which he formulated a view of treatment as a kind of training

set in a frame of supportive friendship. The basic training principles of Carkhuff's system expose the trainee to various modes of behavior in a goal-directed, action-oriented process. This approach provides a work structure within creative, spontaneous human interaction. Carkhuff's systematic human relations training emphasizes practicing the desired behavior, so that the trainee takes away usable skills, such as the techniques of making eye contact, squaring with the person being addressed, and gauging the effect created. This program of skills training offers a built-in means of assessment. Carkhuff advocates designing professional training programs to focus the trainees' communications skills. He does not believe that the operative dynamics which enable one person to help another are the exclusive province of the credentialed mental health professional.

Joseph Durlack (1979) concurs in his review of 42 studies comparing the effectiveness of professionals and paraprofessionals. He found that paraprofessionals achieve outcomes equal to or better than those of professionals. The strongest support for his conclusions came from modification of specific target symptoms in college students and adults.

Carl Rogers (1973) states flatly that "there are as many certified charlatans and exploiters of people as there are

uncertified." He is convinced that relationship qualities like honesty, unconditional positive regard, nonpossessive warmth, and empathy are what make therapy work, not theoretical training.

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" . . . [We must] help psychologists become true change agents, not simply remedial appliers of psychic Band-Aids."

--Carl R. Rogers, American Psychologist (1973)

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O. Hobart Mowrer (1967) has said, "Today there is an appreciable loss (I am tempted to say 'collapse') of confidence in psychoanalysis, with a new and rather surprising willingness, in lay and professional circles alike, to consider the possibility that something commonly called 'values' may be of central importance here."

This idea is implicit in the development of the community mental health center concept, and in the recognition of the positive effect of client/change-agent similarity. Both trends have increased the need for functional professionals who come from the same community as the client/patient.

In conclusion, extensive evidence indicates that functional professionals can be trained over relatively short periods of time to facilitate positive client/patient change. The studies all indicate that long years of academic training are not a prerequisite for competence. A wide variety of studies show that empathic individuals without extensive professional training can elicit this change as well or better than professional practitioners.

Although evidence indicates that relatively simple "facilitation of communication" skills and core relationship factors are the basis of therapy, it is unlikely that they are sufficient for optimal client benefit. The therapist also needs skills in reassuring and confronting the patient. Perhaps the single most important skill is obtaining feedback from the ultimate recipient of the training process--the patient. Frank (1973) said that nothing has been shown to be more effective than a simple helping relationship.

It should be noted that some of the methodologies in these studies have been criticized for the dearth of long-term follow-up. However, the public would do well to rely on the concrete testament to paraprofessional abilities which is available: their increased use by credentialed professionals, the favorable professional evaluations they

receive, and the results they produce. The unanimity of these results is very impressive.

## A PERSONAL TRAINING THERAPY DOES NOT APPEAR TO INCREASE THE EFFECTIVENESS OF THE THERAPIST

In The Fifth Profession, Henry et al. (1971) surveyed over 200 professionals in the field of psychotherapy in an attempt to profile the professional therapist. They found that 75% of clinical psychologists, 65% of psychiatrists, 64% of social workers, and 97.5% of psychoanalysts had undergone training therapy.* Further, this group was six times more likely to recommend therapy to colleagues than were those who had not had training therapy.

Garfield (1978, 1979) was also curious about this issue, in view of the fact that some experience of therapy has been considered a prerequisite of practice since Freud's time. He reports analogous findings in surveys which determine that more than half the population of clinical psychologists has had personal therapy. These figures do not support the prevailing assumption--made by most training programs and unsuspecting consumers of mental health services--that a personal analysis is not only beneficial, but necessary to produce

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* Since few professionals-in-training fulfill the stringent requirements of traditional analysis, which comprises sessions five days a week, the term "training therapy" is used in this section to encompass all forms of psychoanalysis and psychotherapeutic experience.

effective therapists.

Surprisingly little research has been done on the topic, considering the time and money invested in the highly renowned training analysis. Furthermore, there is the sensitive issue of the double bind that confronts the analyst-in-training when he bares his soul to his analyst--who also makes judgments about his graduation from the training institute (Szasz, 1979).

What has the scant research on the effectiveness of the training analysis actually turned up?

## Live Studies

Hans Strupp did one of the earliest studies in this area in 1955. He compared therapists who had been analyzed with a group who had not undergone analysis by having each rate 27 one-paragraph vignettes. There were 30 therapists in each group, and Strupp found that having been analyzed correlated with being a more effective therapist.

However, his friend Garfield (1979) called Strupp to account in a review of the study. Garfield labeled the research poor and uncharacteristic of Strupp, whom he regards highly. Closer examination had revealed that 23 out of 30 therapists in the analyzed group were experienced, while the unanalyzed group contained only two experienced therapists.

Since the profound linkage of experience with effectiveness overrides traditional training, the results were contaminated.

Gordon Derner of Adelphi University did a pair of revealing experiments along these lines (Garfield, 1979). In an attempt to explore the relationship between training therapy and therapeutic effectiveness, he ranked two therapists from the top of a class in a four-year training course and two from the bottom. In his second study, senior university staff ranked the eight most effective therapists and the eight least effective therapists. Half of each group in both studies had been analyzed, and Derner found that training therapy had no effect on the performance of any of the participants within the various groups.

Garfield and Bergin (1975) also did a study on the value of a personal analysis. Their results indicated that therapists who had not undergone training therapy evoked the greatest client/patient change. However, the results of this study are too small to draw sweeping, concrete conclusions.

At this point, the burden of proof in support of training analysis lies with its proponents. Extensive surveys of the literature by key researchers have not revealed evidence to support the utility of the costly training analysis tradition-

ally undergone by therapists (Garfield, 1979; Garfield and Bergin, 1978; Hogan, 1979; Gurman and Razin, 1977, Meltzoff and Kornreich, 1970).

The Case Against Training Analysis

Critics of the process have an ally in Judd Marmor (1979), former president of the American Psychology Association, who has said, "The increasing prolongation of didactic analysis and supervisory hours that has occurred in most psychoanalytic institutes over the past several decades has...failed to guarantee a better-trained and more scientific group of psychoanalysts. [Indeed] the unhealthy and authoritarian hegemony of training analysts over their candidates may be having a contrary effect [by] fostering rigidity and dogmatism. If psychoanalysis is to remain vital, it must be open to growth and change like any other branch of science, and its practitioners must be flexible and open to new vistas of knowledge from whatever source."

Marmor goes on to weaken the historical justification by pointing out that in Freud's time there was no compulsory training analysis; three or four long walks in the evening were sufficient. He indicts training institutes which have "tended to become guardians and perpetrators of a tradition, rather than the education and research centers in which educational freedom [is] allowed to flourish." In such institutes,

he finds that "psychoanalytic candidates who [dare] to question the theoretical structure [are] charged with being emotionally 'resistant' to the revealed truth and therefore in need of more analysis."

In the words of Glover, as cited by Marmor (1979), "The teacher's error tends to become the student's cult."

## THERAPISTS WHO HAVE UNDERGONE TRADITIONAL TRAINING ARE NOT MORE EFFECTIVE THAN THOSE WHO HAVE NOT

Although there is scant empirical research on traditional training in psychotherapy, the findings indicate, almost uniformly, that it is an overvalued commodity. There is almost no evidence that traditional training increases the student's therapeutic effectiveness (Hogan, 1979). This is not surprising in light of the fact that traditional training is not related to client/patient outcome in any way. A novice psychotherapist's success is usually judged by a supervisor's ratings, which are notoriously unreliable (Marmor, 1979). Further, Szasz (1979) describes the problem of double agency created by the system: the trainee tells secrets to the training analyst who communicates his judgment of the trainee's competence to others on the staff. The potential for demoralizing repercussions in this process is enormous.

According to Henry et al. (1971), most psychologists and psychiatrists report that their professional training has not proved useful. Traditional psychology training places the major emphasis on research, while medical school affords little opportunity for practice. The students who are selected to enter these training programs are chosen on the basis of academic grades and aptitudes. In addition, relatively little

attention is paid to selecting personality characteristics relevant to therapeutic effectiveness. David McClelland (1973), found that academic grades predict nothing but future grades or results on tests similar to those used in establishing grades. Hogan (1979) concluded from existing data that only one out of three people entering professional training possesses the requisite interpersonal skills to be helpful to client/patients.

What do we know about training?

The extensive research on training conducted by Carkhuff and Truax has shown that basic interpersonal skills and helping relationships are the essence of both training and therapy. They also pointed out that the quality of the trainee's interpersonal functioning is partly determined by the trainer's abilities in that area. In other words, a trainee with a good personality who is lucky enough to get a good trainer will tend to be good. If the trainer is less empathic, warm, and genuine than the trainee, the trainee's capabilities will be diminished by the association (Carkhuff & Berenson, 1976). Their 1965 study demonstrated that highly didactic trainer approaches do not usually produce patient improvement. The format they endorse for teaching effective psychotherapy is a combination of teaching and experiential training with feedback.

The Magic of Feedback

In his book Kids Don't Learn From Teachers They Don't Like, Aspy (1977) provides dramatic illustrations of the value of feedback. After listening to tapes of classes, he observed that in a typical third-grade reading class the response to children's performances was invariable, "Next." He assumed that this must be disconcerting and instructed teachers to incorporate such words as "happy," "sad," or "angry" in their responses. Teachers were encouraged to say "You feel happy because you got all of the words right," or "You feel sad because you still can't get those words," The results were dramatic. Students given these new responses made far greater gains in reading than those rewarded by the traditional "next."

Two formal training programs which involve extensive use of feedback are filial training, developed by Guerney and his associates at the University of Massachusetts, and micro-counseling, developed primarily by Alan Ivy, who presented his work in a paper at the 1979 meeting of the American Psychology Association.

Filial training is another variation on the didactic-plus-experiential approach. Like Truax, Carkhuff, and Ivy, Guerney operates from a Rogerian point of view. His focus is on helping parents/couples become more empathic and

genuine.

In one study by Stover and Guerney (1969), mothers who received psychological services at a university child-care clinic were divided into four groups of six to eight mothers. All four groups spent 30 minutes in a tape-recorded play session with their children. Then two designated control groups were asked to wait four months before returning for another session with their children. The two experimental groups continued to meet for 10 weekly sessions, during which the mothers were given constant feedback on their behavior in a classic didactic/experiential teaching mode.

When all four groups were compared at the end of the four-month period, the results were impressive. The mothers in the experimental groups showed a marked increase in reflective behavior, compared to the controls, and their children exhibited more expressive behavior than those in the control groups.

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"Evidence indicates that with most populations communication is best learned by practicing communication."

--Robert Carkhuff, Helping and Human Relations, 1969

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Both results represent constructive change of incalculable value on several levels. These new approaches have the added benefit of improving communication which, in the view of Ruesch & Bateson (1968), is "synonymous with adaptation and life." It is unfortunate that although most of the research in this area appears to have yielded positive results, some is methodologically weak. There is great potential for further investigation.

Ivy (1979) focuses on highly specific skills, such as maintaining eye contact, and employs some techniques of behavior modification. Using these methods, he managed to produce, within five hours, a significant increase in eye contact on the part of trainees, and consequently, an increase in their ability to follow and summarize verbal exchanges with the client/patient accurately. Ivy's trainees performed better than the control groups and received better ratings from clients/patients. Positive changes also occurred in the students' self-confidence.

To produce these dramatic results, Ivy broke down the requisite interpersonal skills into molecular behavior and videotaped a proper model of each skill. He introduced the particular skill to each counselor-in-training and then videotaped the trainee's performance with a real person. Accom-

panying this step-by-step breakdown was a live supervisor and an instruction manual explaining the proper procedure for each step. It is not surprising that such a thorough, concrete approach yielded favorable results. Gurman and Razin (1977) offer a more comprehensive description of this method of training.

## New Directions

At this point, psychotherapy finds itself polarized: practitioners of the traditional disciplines are frequently overtrained and sometimes undereffective, while effective paraprofessionals function on good instincts and minimum skills training.

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"More than any other discipline, mental health emphasizes that knowledge must flow in both directions, from practice to research as freely as from research to practice."

--Dr. T. A. Lambo, World Health, The Magazine of the World Health Organization, 1977

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The obvious solution is to define consultant roles for psychiatrists and clinical psychologists and design an

interface with the paraprofessionals.

However, this daring undertaking will be possible only when the psychotherapeutic community as a whole focuses attention on the ultimate recipient of its services, the client/patient, rather than on the sanctity of the discipline itself. Then the full weight of the experience-effectiveness equation can be brought to bear on client/patient therapy at all levels. More importantly, the time required to achieve competence as a therapist can be dramatically reduced, and irrelevant or counterproductive training can be eliminated. Psychotherapists must learn to measure and think in terms of results, as the business community does. They must set therapeutic outcome as their goal and aim their training strategies accordingly. As simple as it seems, this concept is considered too radical for most traditional training programs.

If the community is willing to take a hard look at the realities of patient outcome, there is substantive support for this results-orientation in the history of the profession: Freud said, "I would advise you to set aside your therapeutic ambitions and try to understand what is happening. And when you have done that, therapy will take care of itself." (Lennard and Bernstein, 1960)

# MATCHING THERAPIST AND PATIENT INCREASES THE EFFICACY OF THERAPY

Congruent matching of therapists with patients is one of the most neglected areas in the performance of psychotherapy. Matching is something we know little about. The application of what we know to actual practice is in its infancy.

## Who is Good for Whom?

Asked what it means to be a good therapist, Arnold Lazarus said, "Being good doesn't mean very much, and I'll tell you why. 'Good for whom' is the question. . . . For those seeking a paid friend or companion, just being there is enough." Lazarus feels that referral practices are key. Since we all have strengths and weaknesses and proclivities and prejudices, we are more effective with some people than with others. For instance, Lazarus himself prefers to send a militant female patient to a loving, middle-aged female therapist, rather than battle the patient for six months to achieve a therapeutic relationship which enables her to learn more appropriate behaviors.

However, it is not always strengths and weaknesses that determine an effective match of therapist and patient. People are also motivated by strong idiosyncratic needs which are not

immediately recognized. Lester Luborsky (1975, 1979) has had some fascinating results in the area of matching. He describes Mrs. D. R., who applied for treatment with one therapist and dropped out after five or six sessions, complaining of his shortcomings. She then went to a second therapist and repeated the behavior, indicating that she felt she was going to be manipulated and subjected to nonproductive procedures. Upon introduction to a third therapist, she said almost immediately, "I know this will work." Questioned about her conviction, she said that the therapist had narrow feet like an important man in her life with whom she was trying to sever relations. She also noticed that the therapist's shoes were not well-polished, and she felt that this implied a nonmaterialistic nature. In analysts' terms, she based her decision on "prior object relations."

## Predictor of Success

Luborsky went on to develop a predictor of outcome more accurate than pretreatment variables. He devised a system for plotting helping relationships, based on two judges' ratings of patient transcripts. The judges reviewed two early sessions and two late sessions in the therapies of 80 patients. Then Luborsky analyzed the scores of the 10 patients judged most-improved and the 10 judged least-improved. He found

that patients who had a low helping-alliance score by the third session did poorly. In other words, therapy outcome could be predicted by the third session.

What can we do with this finding?

Luborsky suggests that if patients could try several therapists and select one on the basis of their feelings, better results would ensue. To facilitate the process, he recommends that therapists supply film clips or videotapes of themselves doing therapy. The experiment he designed and conducted along these lines bears out his thesis.

This idea has great promise for a number of reasons. Its primary value would be to take the onus of potential failure off the already demoralized patient and increase the chance of achieving a successful match early and easily. Most therapists initially resist the proposition because it does not appear to be economical. At first glance it appears to be hard not only on the pocketbook, but also on the ego. Who wants to be rejected? However, this approach holds the promise of benefits for everyone. Increased therapeutic effectiveness would result from an environment where knowledge and referrals were shared. Gains would be realized in many dimensions.

Empathy As an Indicator

After an extensive review of the literature, Daniel Hogan concluded that empathy in a therapist is the most potent indicator of the capacity to induce therapeutic change. The practical applications of this idea are readily available because empathy can be measured reliably by various test scores and judgments like the Carkhuff-Truax Empathy Scale.

The importance of well-developed empathy in a therapist cannot be underestimated. A nonempathic therapist can be extremely harmful. Even a therapist with average empathic capacity can cause damage if he is functioning at a lower level than the patient. Bergin (1979) reports that about 10% of all patients deteriorate in therapy because of the quality of the patient-therapist interaction.

A variety of remedies have been suggested to counter this trend. Hogan feels that the therapist must develop an awareness of his own limitations, techniques, and values and make this knowledge available to the public so that the selection of a therapist is less like a blind date.

In a 1979 interview he stated, "I would worry more about someone who was very competent but had no idea of his limitations," than about a less competent practitioner who

knows his limitations. This suggests that self-disclosure statements would be more useful in selecting a therapist than the present system of state licensing, which misleads the public because it is not based on functional criteria. To be maximally helpful, such self-disclosure statements would consist of resume-type information, including fees, methods used in therapy, projected duration of therapy, and perhaps a statement of ethics.

Weighting Values

It is a fact of human nature that it is easier to empathize with someone who shares similar values, but at present there is no standard way for the public to get acquainted with a therapist's values. He must buy them blind, as it were. Traditional psychoanalytic dogma often states that therapy should be "value free," but value free is a heavy value in itself.

Bergin (1979) believes that the therapist makes value judgments all the time in the process of therapy and that he always transmits his values to some extent, as a parent does. In Bergin's view, the therapy process teaches, and the therapist teaches values just with his questions and comments. He sees therapy as pathology-oriented and supportive of existing social values. It follows that Bergin does not think the

transference of values is bad, but natural. His personal teaching hypothesis is that fostering forgiveness toward parents and others who have contributed to the client/patient's problem helps to alleviate symptoms. He further believes that teaching love, commitment, service, and sacrifice for others heals interpersonal difficulties and distress. He makes his belief system public so that anyone who comes to him for therapy knows this beforehand.

Harry Stack Sullivan, an eminent post-Freudian writer and analyst, felt that personality is an intrinsically interpersonal product which is molded by the evaluation of significant others. His concept was one of reciprocal emotion; he suggested that in the therapist-patient dyad, each had to supply what the other needed. The Sullivan theory would pair, for instance, a rebellious, distrustful patient with a hypernormal therapist or a competitive, narcissistic patient with a docile, more dependent therapist. The idea of matching dissimilar dyads is also supported in the work of Sutherland, who felt it produced the most successful outcomes (Gurman & Razin, 1977).

The selection of a therapist must be based on qualities as diverse and comprehensive as those applied to the selection of partners in other relationships--spouse, workmates, friends.

The variables involved may be as basic as values or conceptual level, or as superficial as shoe polish, but the patient must be able to pick a therapist who talks his language, with whom he shares a mutual regard.

## CONCLUSIONS

The therapy enterprise is suffering from what George Kelly labeled "the insidious disease called hardening of the categories" (Sjoden, Bates and Dockens III, 1979). Schools of thought which started out as brave pioneering attempts at human self-actualization have become defensive and mistrustful of research.

The volumes of psychotherapy research findings available in libraries today are not being consulted and used. They are not being taught to therapists in training. The new directions indicated in the research are not being followed up by the therapeutic establishment. There is a dichotomy between research and practice, which must prompt us to ask:

Why do we continue what we are doing when there is good evidence that what we are doing is wrong? What can we do to illuminate those involved in the therapy process? What new procedures might be developed, based upon research conclusions? Dare we insist upon meaningful regulation, rather than government support of arbitrary standards? What can we do to establish an Academy of Life Skills free of unproductive allegiances and rigid historical notions?

Would it not be profitable to establish therapist-patient matching services using videotapes or films of the therapist in action? Where do we begin? What makes people grow?

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"So we come back to the place from which we started--seeing that place in wider perspective. The place is a university, and we are its Board of Regents. The wider perspective is about perspectives, and the question posed is: Do we, as a Board, foster whatever will promote in students, in faculty, and around the boardroom table those wider perspectives which will bring our system back into an appropriate synchrony or harmony between rigor and imagination?

"As teachers, are we wise?"

--Gregory Bateson, Mind and Nature, a Necessary Unity, 1979

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## Section Five

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# Section Six

## WORKBOOK:

## ACTUALIZING EFFECTIVE PSYCHOTHERAPY

Report on Effective Psychotherapy: Legislative Testimony is designed as an ongoing, proactive document.

Reports are only as valuable as the informed action they generate. It is the purpose of this document to elicit reader response to the questions on the succeeding pages.

Mail replies to: Roberta Russell
R.R. Latin Associates, Inc.
404 East 55th Street
New York, New York 10022

Replies will be reviewed and categorized with the intent of establishing a data base for the use of the psychotherapeutic community at large. Trends will be analyzed and channeled to appropriate policy-making agencies, along with specific reader reactions.

## The Psychotherapeutic Encounter

Most of us have had counseling or psychotherapy at some point in our lives, in the form of marriage counseling, pastoral counseling, Parent Effectiveness Training, or one of the other services available in our society. Recall psychotherapeutic experiences—either your own or others'—which have shaped your thinking about the field as a whole. In the space provided, jot down a brief description of the highlights of these encounters, whether they were successful or unsuccessful. Specific names and places are not necessary.

| Successful | Unsuccessful |
| --- | --- |

What Makes People Grow?

1. What, in your opinion, makes people grow?

2. What therapeutic techniques are growth-producing?

3. What therapeutic methods discourage growth?

4. Do you feel that self-disclosure statements by practitioners would be a useful device for client/patients who are selecting a psychotherapist?

5. What kinds of information would you like to see included in self-disclosure statements?

6. Should therapists define their competencies by identifying the personality types with whom they work most effectively?

7. Where should these records be kept? Who should have control of them? Who should have access to them?

8. If you were a client/patient, would you like to participate in a videotaped review of your therapeutic progress conducted by therapists chosen for their demonstrated capability with your particular problem and personality?

9. Do you think such a trial program for an Academy of Life Skills might be a good pilot effort to isolate the "active ingredients" in the therapy process?

10. Should current licensing laws for psychotherapists in your state or country be changed? If so, how?

11. Do you believe that any particular discipline of psychotherapeutic theory should be regulated by the government? If not the government, what regulatory body would you recommend?

12. What other areas would you like to see investigated in this manner?

13. Would you like to be informed of the response to this questionnaire?

Name: _____

Mailing address: _____

Telephone: _____

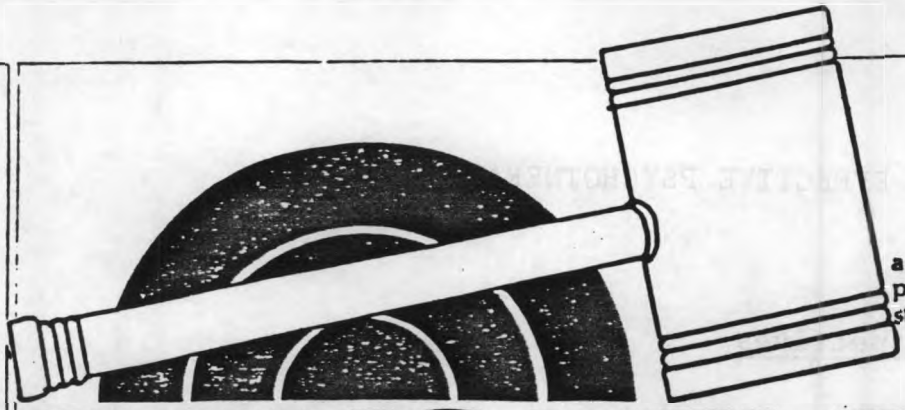
Occupation: _____

Additional remarks/comments/queries:

## Wider Perspectives

Assume that you sit on the Board of Regents of a world-wide university which has been empowered to create a model system for the practice of psychotherapy. The Chairman of the Board has called upon you to expand your horizons and envision the future. Draw upon your experience and your hopes for the future to set your goals and action plan your implementation. State your strategy and your tactics, what groups you would contact and what methods you would use. Use the Legislative Testimony as a frame of reference to guide you in formulating your suggestions. Refer to Gregory Bateson's charge to his board (page 59).

January 1981



a newsletter for public members on state licensing boards

# The PUBLIC MEMBER

## You Can Make a Difference!

At the national advisory council meeting for this newsletter, law professor Nat Hershey asked a question on everyone's mind: "Has any public member ever accomplished anything that could be nailed down?"

The question arises because there is so little documentation of public-member effectiveness. We do know of a

*The contractors fair and tough they planne testimoni contro wor f*

New York State Assembly
COMMITTEE ON HIGHER EDUCATION

Please reply to:
Committee Offices
Room 842
Legislative Office Bldg.
Albany, New York 12248
(518) 455-4794

Room 728
270 Broadway
New York, New York 10007
(212) 488-6750
488-6950

MARK ALAN SIEGEL
Chair

NOTICE OF PUBLIC HEARING

SUBJECT: THE REGULATION OF MENTAL HEALTH PRACTITIONERS

DATE: THURSDAY, MARCH 5, 1981

TIME: 10:00 A.M.

PLACE: CUNY GRADUATE CENTER
33 WEST 42ND STREET
3RD FLOOR STUDIO
NEW YORK CITY

10:00
3:00

SCHEDULE OF WITNESSES

Daniel B. Hogan
Mortimer Cohen
Roberta Russell

HEALTH PRACTITIONE
ULATION OF
LC HEARING

for he
w book
ners Union
tition State G
nd Harry Sny
dministrative
rks. Petitioning
intercession of a
xpensive and
court

STOP "REINVENTIN
THE WHEEL" . . .

Others may have solved your proble
Others may be creating problems for y
what's happening in:

- certification
- licensing
- third-party reimbursement
- manpower development
- competence assessment
- professional ethics
- public protection
- job training and ma
- continuing educat

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bring you the

4, p. 2)

# LEGISLATIVE TESTIMONY

SUBJECT: REGULATION OF MENTAL HEALTH PRACTITIONERS

TO: THE NEW YORK STATE ASSEMBLY HIGHER EDUCATION COMMITTEE,
MARK ALAN SIEGEL, CHAIR

FROM: ROBERTA RUSSELL

DATE: THURSDAY, MARCH 5, 1981

I. 1) Mental health practice is largely the function of human relationship skills between patient and therapist or paraprofessional, the goal of which is to increase the patient's options.

2) Mental health practice may be defined as a verbal treatment in order to affect the patient's feelings and behavior in a desirable way.

3) Competence can be reviewed by setting identifiable objectives and periodically reviewing progress according to objective predetermined standards, such as symptom removal and increased sense of well-being. It can be identified and reviewed by using multiple measures of outcome over time, with control groups and one-year follow-ups.

4) Academic background and training do not assure or even correlate with practitioner competence. Training by a mentor of demonstrated competence is probably more valuable than academic training or supervision under a person who has proven to be relatively ineffective.

II. A) New titles should be established in relationship to a practitioner's area of special competence, such as, <u>Child Therapist</u>.

B) No regulation is better than regulation based on standards that have nothing to do with patient

improvement. Such regulations, which are currently in existence, are misleading to the public.

C) Perhaps a more appropriate regulatory structure would be a national register of practicing therapists. This registration would encompass all disciplines of therapy practice and would list the therapist's

1) Values
2) Techniques used
3) Past experience administering therapy and successes
4) Education
5) References
6) A videotape of a sample therapy session

Registration would be voluntary, and the information would be a matter of public record.

D) Minimum standards of training and education should include:

1) Training in interpersonal skills such as empathy, responding accurately, etc.

2) Familiarity with psychotherapy outcome research

3) Sponsorship or supervision by one who has had successful results with patients

E) Practitioners who have demonstrated long-term results should be eligible for third-party payments.

III. Our knowledge base in the field of psychotherapy might be further enriched by the active and open participation of some of the innovators in the psychotherapy endeavor, regardless of disciplinary origins.

An Academy of Life Skills could be formed to which therapists could submit videotapes of themselves in session with a patient, their projections, diagnoses, and treatment strategies. Outcome

would be followed up over a period of one year or more.

Board meetings with participating experts would be held periodically and various treatment approaches evaluated. This should be done in the non-partisan results-oriented style common to board meetings in businesses. Recommendations would be shared and reported on a regular basis.

The Academy could be a pivotal learning center incorporating new knowledge into exemplary treatment programs, evaluating the results and disseminating information. For instance, since the value of proper therapist-patient matching has been demonstrated, a program incorporating several initial trials with three different therapists as normal procedure might be standardized by the Academy.

Send all responses & inquiries to Hillgarth Press, P.O. 1440, Lake Placid, N.Y. 12946; Fax/phone: 518-523-1360

Update 1993

# What Is Really Happening When The Client and Therapist Talk?

*"The cure of the soul has to be effected by the use of certain charms, and these charms are fair words,"* Socrates told us about 24 centuries ago. But today's accumulation of research into psychotherapy sheds light on just what those charms might entail and from whence they come.

Diverse schools of thought have proliferated in the exponentially expanding enterprise of therapy. They range from Behavior Therapy, Psychoanalysis, Multimodal Therapy, Cognitive Therapy, Direct Decision Counseling, Bioplasmic Therapy, Rebirthing, Burnout Prevention, Neurotone Therapy, Dance Therapy, Bibliotherapy, Photo Counseling, Soap Opera Therapy, Vita-Erg Therapy, and Zaraleya Psychoenergetic Technique and combinations of the above. Unchecked, this trend would approach solipsism, a psychotherapeutic method for each psychotherapist (Bordin, 1979). The various therapies differ both theoretically and procedurally. Their great variety seem to make it self-evident that they are doing something different (Klein, 1984).

Are their methods really as divergent as they seem to be? Is one method of psychotherapy superior to another? How can one make such a determination? What is really happening when the client and therapist talk? These are questions which research seeks to answer.

**This is the age of accountability; previously most practitioners had few doubts about the efficacy of their own versions of therapy.** In instance after instance, professionals in the field and in the government have been examining the ways psychotherapy is conducted and the results it produces. There has been an irreversible change in professional attitudes about psychotherapy and behavior change. The new view is that the long-term dominance of the major theories has ended and that an eclectic position has taken precedence (Garfield & Bergin, 1986). Professional ethics suggest that the unstandardized proliferation of new methods without objective clinical evaluation is not in the public interest.

~ Psychotherapy's most insistent critic in America is Congress, which has begun to demand clinical proof of its accomplishments before agreeing to finance it under Medicare. Now the burden of proof of the effectiveness of psychotherapy has been shifted to professional researchers in psychology. The professionals are now motivated to justify the exclusivity of their therapeutic methods and win merit in the eyes of insurance reimbursers and government regulators who are important contributors to their income.

~ In the summer of 1992, at an American Psychological Association (APA) Centennial meeting in Washington, D.C., the leaders in psychotherapy-outcome research convened to report on their cumulative findings. They had been relentlessly trying to unravel the mysteries of therapy by examining its processes and effects. Klaus Grawe, Ph.D., a Swiss research psychologist who had been commissioned by the German government—whose National Health Insurance pays for psychotherapy—to report on the outcome of that process was present. He proclaimed that recent methods of investigation into the therapy process have been increasingly refined, particularly in Germany where research funding for such explorations has increased.

~ Sophisticated statistical methods such as meta-analysis, a procedure in which multiple experiments are weighted on important variables and analyzed as a group, that were new at the first publication of this *Report* are currently in vogue. Applications of meta-analysis to psychotherapy outcomes (Smith & Glass, 1977; Glass & Miller, 1980) address the overall question of the extent of benefit associated with psychotherapy as evinced in the literature as a whole, compare the outcomes of different treatments, and examine the impact of methodological features of studies upon the reported effectiveness of treatment. For example, Smith et. al. (1980) found an average effect size of 0.85 standard deviation units over 475 studies comparing treated and untreated groups. This indicates that at the end of treatment, the average treated person is better off than 80% of the untreated sample—a very impressive result for a behavioral science. However, Dr. Hans Esyenck's (1991) view of these statistics give us pause: He points out that what this study claims to have shown is that different types of psychotherapy (verbal or behavioral; psychodynamic, client-centered, or systematic desensitization) do

not produce different types or degrees of benefit; but they carefully fail to add to the list of different types of treatment, the term *placebo*, although the placebo effect is not very different from the average effect of all the types of treatment they have investigated. These findings were more extensively affirmed by Prioleau et. al. (1983) in a study comparing the effects of psychotherapy with a placebo.

Eysenck tellingly adds that when we note that the Glass statistics show that length of treatment is completely uncorrelated with effectiveness of treatment, and that the duration of training of the therapist is completely uncorrelated with the success of the therapy, we begin to see that their conclusion may be more an expression of hope than of fact (in Walker, p. 54). To further underscore his thesis, Eysenck (1993) points to the data of yet another meta-analysis in which nineteen studies that compared psychodynamic psychotherapy and no treatment yielded no difference in outcome (Svartberg, et. al., 1991). These are mean results. In the statistical sense, they represent both patient deterioration and gain. By either analysis there are logically cases in which psychotherapy *is* effective.

If we want to learn what is happening in therapy, we must then look at what goes on moment by moment in the interactions between therapist and patient. We must decide what interactions are creating an effective treatment (Fiske, 1977).

~ New forms of process research in which the effect of each pass between the dyad of patient and therapist, are examined and analyzed by multiple observers, and the patient as well, have proved to be useful predictors of therapeutic gain. One such measure that

has generated international interest is the Structural Analysis of Social Behavior (SASB) which was developed by Dr. Lorna Smith Benjamin (1987, 1992). It has proved to be a very reliable and informative measure of what is happening during the psychotherapeutic hour.

~ Even with the benefit of more precise tools of research no one method of psychotherapy has proved to be most useful in treating the demoralization that most new patients characteristically experience. In fact, professional training in psychotherapy does not generally afford the special expertise that it intends to impart to its students. There are, however, useful techniques that are dramatically effective for very specific disorders (Eysenck, 1991). And the highly touted training analysis which remains an intrinsic part of the psychoanalytic training regimen has still not been shown to increase the therapeutic effectiveness of its beneficiaries, the graduated and analyzed psychoanalyst or psychologist. Insular training institutes with their unremitting focus on the history of psychoanalysis and its theoretical nuances may be compared to religious orders who hotly debated the number of angels on the head of a pin.

According to Donald Klein, M.D., a prominent psychiatrist and Director of Psychiatric Research at the New York State Psychiatric Institute, medically educated psychiatrists could put their training to better use by confining themselves to diagnosing and prescribing, while leaving talk psychotherapy to *others*. Although this view is extreme —there are certainly psychiatrists who are therapeutically gifted as well as medically trained—one still wonders who the *others* that Klein refers to might be? Psychologists, social workers? Paraprofessionals? Perhaps you and me paired off in a well-intentioned

alliance? John Bowlby, the renowned British psychiatrist said that there is a wired-in propensity for relatedness in individuals. How does one learn to find and utilize the appropriate professionals who have the propensity for therapeutic relationships? Is the term professional in its most efficacious sense a moral rather than a social or legal distinction? We now have the tools to discern therapeutic ability and effect.

**Research Can Now Effect Clinical Practice.**

Initially therapy outcome research was often dismissed for being artificial; conducted in a sterile ivory tower and not relevant to practice. Because we are now armed with refined measurement scales, and video tapes and audio tapes of actual sessions, and focused on the process of therapy, and not just its affiliations, this is no longer true. Therapists can now use what they learn from research.

**"Everything depends on the man and little on the method." Carl Jung**

When we look at individual therapist differences instead of treatment differences we can predict 8 times as much variance in therapeutic outcomes (Luborsky, Crits-Christoph, & McLellan, et. al., 1986; Luborsky, McLellan, Woody et. al., 1985). Carl Jung said that everything depends on the man and little on the method. Stimulating therapist style is an important ingredient for change, and successful therapy has to do with effective rhetoric, (Frank, 1991). At last we appear to be on to a truly productive line of inquiry.

In the main, psychotherapists can legitimately bolster their confidence in the knowledge that they are doing some good. Five to six hundred comparative studies summarized by Luborsky (1975, Smith), Glass & Miller (1980) and the giant depression collaborative study of Elkin (1986, 1993), confirm this fact. But not one of the most used forms of psychotherapy has a proven claim to greater effectiveness across the board.

Although an evaluation of the effectiveness of the use of drugs in psychotherapy is not within the scope of this *Report*, Elkin's controversial collaborative research is nevertheless worthy of comment. Two hundred and fifty depressed patients were randomly assigned to an experienced manual-guided therapist following either cognitive behavior or interpersonal therapy guidelines or to a program of imipramine or a placebo, both with clinical guidance. A true understanding of the complex statistics involved would require a career change. *The Wall Street Journal* reported its findings colloquially as follows: "Generally, the researchers cautiously conclude, there is no evidence that psychotherapies are less effective than the antidepressant drug, but there was evidence the psychotherapies were better than the placebo." Elkin reported more fully in several stages, but did not find any major difference in the treatments, only a few slight trends Klein (1993) has cast doubts on the appropriateness of the statistical analysis used in discerning the meager trends, using metaphors to covey his meaning to the non-statistician. He believes that the imipramine group was superior to the other therapies and that some psychotherapy was superior to the placebo. The controversy goes on.

**Nevertheless, not one of the most used forms of psychotherapy has a proven claim to greater effectiveness across the board.**

This current view substantiated the conclusions I had drawn in *Report on Effective Psychotherapy: Legislative Testimony* in 1981. In essence, the *Report* pared down the jargon of psychotherapy to its essentially human effective ingredient, ***empathy***—the ability to feel with another person—translating its optimal manifestations into the common parlance of the language of love, trust, mutuality of intent, hope, and the enhanced well-being one garners from the feeling of not being alone in one's suffering. Today's cumulative research confirms the healing powers of empathy, but shifts our attention to the even more predictive paradigm, the quality of the therapeutic ***alliance*** between the therapist and patient, their shared goals, and common plan of action.

Bordin (1979) described the therapeutic alliance as including 3 features: an agreement on goals, an assignment of tasks and the development of bonds. The helping alliance concept derives from the concept of transference and that of helping sympathetic understanding. Alliance can be reliably measured by the Penn Helping Alliance Scales (Alexander & Luborsky, 1986).

Horvath (1993) investigated alliance outcome along different treatment modalities: cognitive-behavioral, behavioral and interpersonal. It was determined that alliance and outcome were significantly correlated, but the difference between the various treatments and outcome was not statistically significant. The average correlation between outcome and alliance did not relate significantly to school of thought. It is interesting to note that therapist's assessments of alliance are not as predictive as client's assessment of alliance. Therapists may be mislead by their own therapeutic ambitions.

Since the therapist's technical behavior is seen as being significantly influenced by his personal qualities, he is actually viewed as a person exerting influence, rather than an expert applying technique. To be effective the therapist must be very persuasive. Perhaps the quality of persuasiveness in the therapy endeavor is distributed much like it is in the enterprise of sales: In most organizations 80% off all sales are made by 20% of the sales people.

The *Report* was an anthropologically styled investigation of psychotherapy and its outcome literature, which I had done under the aegis of the National Association & American Examining Board of Psychoanalysis, a New York based psychoanalytic accrediting body. Its research conclusions were enhanced by information drawn from interviews with leading psychotherapists—a practice continued in this 1993 update. In the *Report*, I had unexpectedly discovered that except for a few specific disorders such as tics, bed wetting, and some phobias and psychosomatic disorders in which behavioral therapies seem to be preferred, all brands of psychotherapy are equally helpful, in spite of their vastly divergent methodologies and theories.

Recently a distinguished panel of therapy outcome researchers at the American Psychological Association, including Dr. Strupp, a pioneer in creative outcome-research and Dr. Grawe, has also confirmed the conclusions of the Report are still accurate, though they can be refined by some of the latest research on therapeutic alliance.

**Therapy By the Book**

In the absence of one winner across the board in the psychotherapy sweepstakes, recent studies have focused on technique. Some have even supplied the psychotherapists with standardized performance manuals to make their work more amenable to scrutiny. In order to shed light on the procedures actually employed by psychotherapists Dr. Luborsky has initiated what he thinks will be a small revolution in research style. The degree to which a therapist provides the intended form of therapy that is described in a manual is measured by rating scales. Luborsky feels that treatment procedures recommended should be checked against actual treatment manipulations employed. Otherwise meaningful conclusions about what is working in the therapeutic encounter will remain elusive. Because therapist's talk about therapy often has very little to do with their actual performance, a reliable measure of what they are doing can be a powerful tool in determining the effective ingredients in psychotherapy. Appropriate therapist qualities or procedures may have little or nothing to do with school of thought or training. Therapist selection and appropriate matching with clients with whom they can be effective seem to be unsystematically managed, as well. The dominant process in desensitization and traditional analytic therapy are essentially the same. In each case, an attempt is being made to break the cognitive-affective bonds that control behavior (Bergin, 1972). The therapist is actually selling his version of good health.

**Who is Good for Whom?**

Therapists are not interchangeable, nor are patients. Just as in any partnership arrangement, some pairs work better than others. Verbally forthcoming female patients, for example, improve more with spontaneous and forceful therapists. An examination of therapist qualities has a great deal of predictive validity in terms of therapist outcome.

"Healing ability, like musical talent, may well be a widely, but unevenly distributed quality. No amount of training can make a tone deaf person into a musician. Given a modicum of musical talent and sufficient determination, however, anyone can become a passable performer, though not a virtuoso. The same may hold true for psychotherapeutic talent," wrote Dr. Frank (1991) with his characteristic clarity.

And when predicting therapeutic outcome, patient qualities are not far behind. Therapeutic success is also determined by characteristics and qualities of the patient, such as motivation, severity of the problems brought to therapy, and the ability to form a productive working relationship with a therapist (Strupp, 1991).

If the patient is a person who, by virtue of his past life experience is capable of human relatedness and is therefore amenable to learning, even though the person may have suffered traumas and great obstacles, the outcome is likely to be positive. But if early life experiences have been so destructive that human relatedness has failed to acquire any sense of optimism and characterlogical malfunctions have created massive barriers to intimacy and therefore to therapeutic learning, the chances are that therapy will either result in failure or very modest gains (Strupp, 1980).

Strupp examined the therapy process using several rating instruments: the Vanderbilt Psychotherapy Process Scale (VPPS), the Vanderbilt Negative Indicators Scale (VNIS), and Benjamin's Structural Analysis of Social Behavior Scale (SASB). He found that poor therapist self-concept is associated with poor patient outcome (Henry & Strupp, in press). Regardless of the length of their experience, therapists often engage in countertherapeutic interpersonal processes with difficult patients and traditional modes of experience do not rectify this problem. Why not? It seems that both therapists and patients come with prior significant relationship experiences—strangely known as *prior object relations* to those who are are conversaant in *Psychoanlese*—that carry over into their present relationships, not excluding the therapeutic relationship. Attempts to neutralize the therapist's prior object relations through therapeutic training or a training analysis don't seem to do the job. For better or for worse, the therapist's personality is a potent force.

Frank (1991) has found that "the interaction between particular therapists and patients, determined by the personal qualities, values, and expectations of both, contribute more to outcome than does therapeutic technique. Two probable exceptions to this general rule seem to be emerging. The first is that sufficiently prolonged exposure to an anxiety-provoking stimulus may relieve the anxiety linked to that stimulus. The second is that abreaction of an original trauma in a therapeutic context may be essential to alleviating post-traumatic stress disorders...."

**Demoralization: The Perennial Malady**

Jerome Frank, M.D., an innovative pioneer in psychotherapy outcome research who was recently given an award for his distinguished and enduring contribution in this endeavor, still believes that effective factors are the same for all therapies. He suggests that the therapist's personal qualities are the powerful factors and that techniques merely provide the ritual by which these personal changes are mediated. Frank concludes that **most symptoms are related to demoralization, which can be alleviated by the discovery that others have the same problems**. He calls this "universalization." The therapeutic relationship, then, restores the patient's hope, and it is primarily the ability to engender hope that effects change. **Clearly, licensed professionals have no option on hope!**

According to Luborsky at least 75% of all outpatients seeking therapy are demoralized. This condition is potentially curable by features shared by all forms of therapy: a therapeutic relationship in which the therapist demonstrates concern for the patient and provides a rationale and procedure related to it. Differences in the effectiveness of psychotherapy depend more on the morale-enhancing features of different patient-therapist pairs than on different procedures. As indicated by the forementioned Glass study, even a hope-engendering placebo helps to increase the prospective client's sense of well-being. In that context the patient's natural resources are summoned to carry on the work of healing.

Luborsky specifies the main curative factors in therapy as (1) The patient's increased sense of having a supportive ally in the struggle to overcome the repetitive self-defeating patterns of behaviors and thoughts; (2) The patients increased understanding of symptoms and the related Core Conflictual Relationship Theme (CCRT) which entails problems containing major components of which their patient has been unaware. The understanding allows changes in the symptoms and greater mastery over the conflicts that lead to the symptoms (as they are expressed in the CCRT); (3) a more internalized control-mastery system in relation to the conflicts; so that the gains are maintained after the treatment ends.

**Variations on a Theme**

Theoretically the patient has an opportunity to re-experience with the therapist and with others the conflictual relationship problems in the here and now in order to gain more meaningful insight and emotional release that can lead to change. The patient will either remember or repeat the conflictual relationship problems in the relationship with the therapist (Luborsky & Mark, 1991). If one could measure this repetitive theme amidst its many variations, a measure of transference and the therapist's ability to perceive that theme, as compared to the patient's or other observer's ability to do so would be created. This is apparently what Dr. Luborsky has achieved with his concept of Core Conflictual Relationship Theme. It is a theme song from the past that may, in its unexamined state, lock its victim in the grip of Freud's legendary repetition compulsion. Apparently one's conflictual areas perpetuate in the same arena, but with the right attention and motivation these familiar conflicts can be concluded with a happier ending.

Perhaps this sort of scrutiny might yield profitable results in relationships outside of formal therapy as well?

Luborsky's innovative measure of redundancies in relationships are verified by multiple raters and a moderately good level of inter-judge agreement. In the average hourly session the patient tells three to five narratives. The CCRT method requires that the clinician find the components that are most common across the narratives. In each story the clinician attends especially to three components: current in-treatment relationships, current out-of-treatment relationships, and past relationships. Using the CCRT the therapist attends and responds to each sphere of the triad. This facilitates the working through of encapsulating emotional experiences that may have previously frozen the client's behavior into an unnecessarily limited sphere. The therapist is conveying the view that it is possible for the patient to take an attitude of acceptance rather than condemnation toward her feelings. It is possible to alter one's theme through awareness and vigilance.

The therapist tries to be sensitive, allowing the patient to form a helping alliance; to refrain from doing anything to interfere with development of rapport with the patient. She tries to understand and respond to the aspects that are most conflictual and to where the patient can make changes. By doing so the control is hopefully switched from external unmanageable sources to the patient.

Apparently those therapists who are best at finding the themes that are most common across the narratives have a better patient outcome. It helps to perceive what is

happening accurately. Some therapists are better at this than others and this ability has more to do with effective therapist selection than formal training. One's sensibilities may be formed out of the clay of our inherited temperaments and shaped by the interstices of life. The training of would-be professionals who do not have inherent therapeutic talent may be a poor use of resources.

**The Use of Manuals: A Help or a Hindrance?**

The use of manuals to standardize and measure the therapist's conformity to treatment procedures has been effective in predicting successful outcome in a study with drug addicts (Woody, Luborsky, et.al., 1983). Although manuals are used to standardize and determine what therapists are actually doing in the therapy hour, their use is not universally accepted by researchers. Strupp's experiments with therapist use of manuals (1992) do not bear out Luborsky's positive results and consequently he does not share his optimism about the use of manuals in therapy outcome research. Strupp found that those who followed manuals most closely were perceived by the clients in a way that weakened their therapeutic alliance: He reported that the patients felt that the more adhering therapists were more *impatient.* **Interpersonal alliance is a crucial dimension in effective psychotherapy, so it is not difficult to imagine oneself becoming more guarded with a therapist who is blocking his or her spontaneous reactions and filtering them through a group-determined rule book!** Must we then be judiciously real or is this an oxymoron?

But the manual controversy goes on: Luborsky (1993) feels that Strupp's lack of predictive validity with the use of manuals reflects primarily the reluctance of the therapists to use them. Dr. William Smith (1993) of Vanderbilt University feels that the population from which positive correlations of manual adherence to outcome are found might be limited to esoteric groups. This does not seem to be the case. Currently there are at least sixty-eight on-going experiments using the CCRT. Its predictive validity seems promising, but the results are not yet conclusive.

**It Doesn't Hurt to Know What's Happening.**

The forementioned SASB (Structural Analysis of Social Behavior) scale has been developed to analyze the *process* of psychotherapy rather than its final outcome. This scale charts all possible interactions around an axis of affiliation and control. Every utterance by both patient and therapist, as a dyad, is recorded, and is analyzed and rated after the fact by researchers. This method of measurement is in accord with the idea that people think of themselves as others have treated them. **If the therapist is actually disaffirming the client, that client might lose self-regard.**

Since psychotherapist researchers are now aware that **the language of psychotherapy is itself often pejorative to the patient**, they look for the underlying message in the "therapeutic intervention." Many standard accusatory psychotherapeutic ideas are actually formalized cultural accusations. They impede progress (Dryden, 1985). Drs. Jeremy Safran & William Henry (1992) observed that psychotherapists did not usually recognize the ruptures in relationship between the

patient and the therapist. Perhaps they were blinded by their theories and professions? Professionals, just like everyone else, can be unknowingly hostile or judgmental, saying one thing but implying another. Strupp, at the 1992 APA conference in Washington, D.C, admirably provided an example of this with one of his patients, Helen R., who complained that men were making unwanted passes at her. In response, he suggested that she might be encouraging their attentions.

There, Dr. Sol Garfield, an American psychotherapy researcher of long standing, was asked if he saw any difference between a therapeutic relationship and therapeutic technique he said, "I really don't." He added tellingly, "We've never looked at therapist skill."

It doesn't hurt to know what's happening. Apparently, it helps. Those therapists who are able to judge more accurately what is actually happening in the therapeutic hour achieve a superior therapeutic outcome to their less-aware counterparts. It is not surprising to learn that it is easier to form an alliance with a therapist who seems to understand one's life situation. A sophisticated synthesis of the last 10 years of research done with meta-analysis—analyzing 24 independent pieces of outcome literature—shows that there is definitely a relationship between outcome and alliance. Alliance, as judged by the client, is an even better predictor than empathy (Horvath and Symonds, 1991)! **Alliance is both a precondition and a mechanism for change. If the patient and therapist do not have a good alliance by the third session they are almost doomed to failure!** (Safran & Horvath, 1993).

**The Treatment-resistant Patient**

Regardless of the therapist's skills, not all patients are equally susceptible to therapeutic interventions. There are those that go to therapy perpetually to satisfy dependencies or narcissistic needs to talk about themselves without the burden of reciprocating with similar attention. This is not intrinsically bad, but is not to be confused with the ideally sought after growth and increase of options that therapeutic clients traditionally seek.

**The Inappropriate Match**

No matter what kind of psychotherapy you champion, the sorry fact remains that at least 30 to 40 percent of clients are not being helped. This often has to do with negative complementarity, or Kohut's notion of empathic failure, (when the therapist just doesn't recognize the patient's intent and creates a rupture in the interchange. Studies reveal that the therapists who are the most eloquent in waxing away about patient dynamics are more often than not the ones who cannot see the rupture (Smith, 1993). Certain patterns lead to breakdowns in the therapeutic alliance: the patient experiences being criticized; the therapist is reenacting a pattern familiar to the patient. We create what Martin Buber called a misencounter.

According to Allen Bergin, about 10 percent of the time patients are actually *harmed* by psychotherapy. Therefore it seems reasonable to evaluate your choice of partner or

therapist during an initial trial period of a few sessions. If a sense of alliance is not formed by then, it might be best to try another person. Unfortunately, depressed patients often blame themselves for therapeutic failures and prolong ineffective or even harmful relationships unnecessarily. This phenomenon is hardly surprising since it regularly occurs in relationships outside of formal psychotherapy.

**The Secret is in the Balance:**

**All relationships have ruptures, but it is the corrective emotional experience that is regarded as the primary organ of change.** Psychotherapists who are informed by up-to-date research now know that both the patient and therapist are always contributing to the interaction. And contrary to traditional psychoanalytic dogma, the therapist does not uncover an actual historical reality, but reality as it is constructed by the patient and the therapist together.

In general, the research findings concerning responsiveness to interview psychotherapies confirm what common sense predicts: The better a person's overall emotional health, the more likely it is that he or she will benefit from psychotherapy.(Frank, 1991)

The following assay of the ingredients in a healing relationship is my synthesis of the research literature and common sense:

## Healing Relationships: An Assay

1. Healing relationships are available to humanity at large and are not the exclusive province of psychotherapists.

2. The most active ingredients in effective psychotherapy are empathy and a feeling of alliance.

3. Anyone who still has a reasonable capacity for trust and sufficient motivation can form healing relationships.

4. We are all engaged in the business of self-deception. Our attention-selector filters are always active and we screen out much of what is too painful to notice. No one is fully conscious all the time.

5. In order to fill some of the lacuna that self-deception creates, we engage in maladaptive behaviors—We drink or eat or drug ourselves too much in order to numb the pains of life.

6. These compulsive behaviors have immediate rewards of their own and are therefore sometimes addictive as well.

7. It is easier to see compulsive and/or addictive behavior in others than it is to catch ourselves in the act. This is particularly true if the other offers at least some slight

variation on our own theme. (A completely like-minded companion is breeding ground for a *folie a deux.*)

8. Formal psychotherapy, once underway, entails a working agreement replete with goals and ground rules to reach those goals. Likewise, other relationships can be carefully and thoughtfully created for mutual benefit and braced, as therapy is, by a constructive thing to do together. Effective techniques used in therapy can be used in well-intentioned relationships outside of formal therapy as well.

9. Feelings of empathy and alliance may be engendered through this goal-oriented relationship. In other words one might find a friend or enhance an existing friendship and increase one's options, too.

10. Certain conditions have been shown to enhance the possibility of empathy and trust and alleviate loneliness. They are:

a. honesty
b. reliability
c. openness
d. acceptance
e. clear feedback
f. sensitivity

11. An empathetic relationship is breeding ground for insight. Because it is safe, less self-insulating, defensive behavior (the enemy of awareness) is employed. New insights may lead to more courageous and goal-oriented behavior.

12. Relationships which involve a mutual commitment and go beyond polite behavior often have a denouement similar to a classical psychoanalytic relationship. The stages of development are:

a. exploration
b. resistance
c. transference
d. suffering
e. reality testing
f. resolutions
g. increased options

13. Once our expectations of each other are both consistent and realistic, the unproductive energy formerly spent maintaining illusions is now free to address reality. We may gain increased fortitude through the alliance with another person. Safer in the world with an ally, we are more willing to take risks, because we now have more meaning.

14. Significant change is predicated by desire to change. Alliance alone is not enough.

According to Dr. Harold Greenwald therapy consists of deciding on goals; looking at decisions and irrational beliefs, and identifying a central theme. **The decision to change is crucial.** What can we do with what we now know? How can we turn this hard-won knowledge to account?

**Pairing With Someone Who Is Good For You**

Dr. Carl Whitaker, a highly regarded leader in family therapy believes that psychotherapy is a form of encounter. It is a process that accelerates the growth of a person. The product is greater interpersonal competence. What is not psychotherapy is any kind of intervention or relationship that does not aim to produce growth.

Is therapy, then, possible outside of the formal confines of the therapist's armamentarium: his personal analysis, professional training, couch, and accrediting degrees? What result would we produce if we paired well-intentioned congenial people with the mutual purpose of forming and maintaining a therapeutic alliance?

Irving Janis (1982) did just that in his weight reduction study at Yale. He explored the inherent possibilities in a goal-oriented relationship and regular contact with a jointly motivated companion. He discerned that a therapeutic partner must succeed in creating an authentic image of an enhancer of self-esteem.

The image of a helper as a generally dependable source of self-esteem enhancement provides a framework that might account for what happens in a variety of other dyadic relationships—between a student and a teacher, a novice and a guru, a pair of work colleagues, friends, lovers or marital partners. Self-disclosure usually occurs in all of these relationships, whether unwittingly or by design. If the pairs feel mutually accepted they go on.

In phase 2 acceptance becomes conditional, at least in some instances. If these exceptions center around commonly-agreed-upon mutual goals, and general acceptance is still communicated, the trust built upon in the first phase will carry the relationship through the rough spots.

In the third phase of the relationship the influence of the norm-sending helper is threatened by the client's disappointment at the eventual termination of direct contact, unless the ending is softened by assurances of continual positive regard and an arrangement for a gradual rather than an abrupt ending of the relationship. The helper encourages the helpee to "work through" feelings about termination and to look forward to future satisfactions that can come from increased autonomy and mastery.

Janis (1982) has also reported other successful instances of therapeutic pairing. In a study of short-term counseling for antismoking, successful long-term outcome depended upon whether the counselor had used the supplementary procedure of assigning his clients to partnerships, with instructions to phone each other every day for five weeks. The clients who were given this supplementary procedure during the period when they came for weekly sessions with the counselor showed a highly significant sustained beneficial effect after 1 year and also after 10 years. The control clients who were not given this partnership , showed no substantial decrease in smoking after 1 year or after 10 years. The same effects were observed when Janis augmented partnerships in a weight-reduction clinic.

Of what use is this to therapists? Clearly, yoking patients appears to be a cost-effective and promising paradigm awaiting therapist implementation. Having a partner is a powerful force in reducing demoralization.

**Tutors and Tutees: Teaching is Learning**

Another dramatic use of improvement through peer helpers was reported by Robert Cloward in his study of teenagers as tutors of academically low-achieving children. Surprisingly, when average students tutored low-achieving students who were 2 grades lower, the tutors reading levels jumped almost 2 years more than the control group, an even greater gain than the tutee's . Personality characteristics of the tutors appeared to be better predictors of their effectiveness as tutors than their academic achievements. Students with lower than average reading scores seemed just as effective as those with higher than average reading scores. The tutorial situation may be a fruitful area for investigation in therapeutic helping relationships as well. Teaching is one of the best ways to learn.

**The Magic of a Single Session**

According to Dr. Moshe Talmon (1991), the most common number of sessions for any single patient in the average caseload is one. Forty percent of all patients across the board, go only once and drop out. Is this the result of poor matching of patient and therapist? Talmon was both surprised and pleased to report that this is not the case. Seventy-eighty percent off all patients who quit after the first session report that they stopped because they got what they wanted, presumably a strategic intervention.

Apparently the therapy starts the moment a patient picks up a phone to call the therapist or clinic. If the preliminary questioning by the therapist is handled skillfully, the client starts to focus and resolve her troublesome issues. Talmon studied one hundred thousand outpatient appointments over a five year period and still his surprising statistics confirming the power of a single session were constant.

Most therapists focus on the negative side of single session therapy, and think of it as a failure. Once again, professionals may use what they learn in research. Knowing this strange fact, how might one make use of it in the all-important first and last session? Would a routine follow-up enhance mutual effectiveness? Could the first interview be structured differently to maximize what might really be a strategic intervention?

There is much to learn from the free interdiciplinary flow of information and the lessening of the crippling hold of insular loyalties. Ultimately the dissemination of knowledge from research to practice will enhance the power we bring to bear in our encounters with others.

*"Psychotherapy consists of the paring away of all that stands between us, the props, masks, roles, lies, defenses, anxieties, projections, and introjections, in short all the carryovers from the past, transference and countertransference that we use by habit and collusion wittingly or unwittingly, as our currency for relationships."*

R. D. Laing, The Politics of Experience

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# Update 1994

## The Age of Accountability: Crisis or Opportunity?

This year has thus far been a hotbed of political activity for the psychotherapy profession. In response to the accelerating demands for accountability by government and insurance reimbursers, increasingly sophisticated attempts at tracking the *normal* course of successful psychotherapy treatments and their relative outcomes have emerged. What works in psychotherapy? For whom? In how much time? These questions remain at the core of research exploration.

### A Better Meta-meta-analysis?

One new tool for such investigation, the *meta-meta analysis*, introduced by Mark W. Lipsey, Ph.D in December, 1993, has already spawned a rash of commentary. In an attempt to shed light on the complexities inherent in this web of analysis, its predecessor, the meta-analysis, will be initially examined here. *Meta* comes from the Greek word which means after; in this instance, it refers to the analysis after the meta-

analyses. Since it is impossible, even for the most scholarly researcher, to be an expert in all areas, one must strive to maintain a healthy balance of trust and skepticism, when evaluating abstract data that others have derived.

**The Myth and Mystification of Meta-analysis**

In 1979, Smith, Glass and Miller, a now-disbanded team of researchers, were launched into the limelight of the psychotherapy research arena with their now-classic, and frequently quoted meta-analysis of 475 experiments exploring the relative effectiveness of divergent methods of psychotherapy. The meta-analysis, formalized in *The Benefits of Psychotherapy* (Johns Hopkins Press, 1980), concluded:

"Different types of psychotherapy (verbal or behavioral); psychodynamic, client-centered, or systematic desensitization) do not produce different types or degrees of benefit. (p.184)"

The authors began by weighing each experiment with regard for its excellence in methodology or lack of it, and then compared all the effect sizes of the diverse methodologies ranging from Reality Therapy to Cognitive Behavior Therapy. Specifically their seminal study intended that, "The results should seem connected closely to the original data (i.e., the findings of hundreds of outcome studies themselves) so that the reader suffers few worries about being several steps removed from the primary evidence." (Smith, M.L, et.al., 1980, p.4) After extensive statistical

analysis of their voluminous material they concluded that psychotherapy works without regard for school of thought. They also came to the following seemingly contradictory conclusions: "....Behavior therapies were more effective than others for neurotics, ... and phobics. Verbal therapies were not reliably more effective for any diagnostic type" (ibid, p.98).

Why?

For Smith et. al. this was only a subset of their most quoted umbrella conclusion: "Different types of psychotherapy (verbal or behavioral; psychodynamic, client-centered, or systematic desensitization) do not produce different types or degrees of benefit." (ibid, p. 184). It was this umbrella conclusion, which was drawn from their published analysis of their data, that was a shot heard around the research world. The published effect sizes of the methods of psychotherapy studied ranged from .14 for Reality Therapy to 2.38 for Cognitive Behavior Therapy. Although these effect sizes might appear far from equal to anyone familiar with their usual meaning, the author's authoritative conclusions were quoted, and accepted even though to some they seemed to belie common sense. Apparently, their conclusions were born of a considered, but questionable procedure.

Many sophisticated researchers, with the notable exception of the British psychologist, Dr. Hans Eysenck, Ph.D, accepted the not-unpalatable "finding," that all methods of psychotherapy that were examined were not only effective, but also equally effective, as well. In my 1981 review of the literature in *Report on Effective Psychotherapy:*

*Legislative Testimony*, I, too, accepted this summation, on faith, attributing the large reported differences in the effect sizes of some of the 18 methods of treatment to my dearth of experience with the complex procedures of meta-analysis, which turned them magically, into equally proficient methods of therapy. My lack of familiarity with the details of these statistical manipulations was shared by many research professionals.

Eysenck's most recently published rebuttal of the Smith, Glass and Miller synopsis drew my attention to its internal contradictions, (Giles, 1993). He pointed out, first, that the disparity in the effect sizes of all methods of psychotherapy tested could hardly be indicative of their equality of effectiveness, and second that the placebo group was about as effective as the average treatment.

This landmark meta-analysis was described by Dr. Jacob Cohen Ph.D., a formidable authority on statistical analysis and the originator of the term *effect size*, as "by far the most important research in psychotherapy ever published,"(1981). Nevertheless, Eysenck's bold challenge to the validity of its conclusions remained ignored by the research world, even though he remains one of the most published and cited psychologists in the world.

***Perhibere testimonium veritate***.
(Hold witness to the truth.)

Incredulous at the rather blaring gaps between apparent evidence and conclusions, and between critical comments and reactions (or lack of them), I set out to find the

truth. The use of complex statistical analyses in research is increasing, and it is also having an escalating effect on methods of medical insurance and governmental reimbursement. Both the psychotherapist and the patient, who may be drastically effected by this turn of events, will benefit from understanding how statistical conclusions are derived, and what they mean. For this reason, and because of the intimidating effects elaborate statistical procedures have on many of us, I will report the particulars of my attempt to achieve a real understanding of these statistically derived conclusions in this *Report Update*.

In my quest, I found myself in search of Smith, Glass and Miller. Dr. Gene Glass, Ph.D. was unreachable; Dr. Mary Smith, Ed.D., the first author of the meta-analysis, was unaware of Dr. Miller's whereabouts, and therefore remained the sole accessible witness to the original meta-analysis.

When asked why the differences in the 18 treatment effects were analyzed to reflect treatment equality, Dr. Smith explained that she was no longer in that field, and didn't remember the statistics involved, but thought that confidence intervals would explain the apparent disparity between data and conclusions. She correctly pointed out that the answers could be found in the formentioned book, *The Benefits of Psychotherapy*. Nevertheless, the prospect of independently discerning the subtleties of the appropriate statistics proved to be both intimidating and inordinately time-consuming. I therefore consulted several seasoned research professionals about Smith's suggested "confidence intervals" explanation.

On this issue, only Eysenck (1994) insisted that confidence intervals simply could not explain the disparity between the differing treatment effect sizes and the conclusion that all treatments are equally effective. He said, "The confidence interval simply means you have a mean. Depending on the size of your group, you can rely on that mean to some extent. The true mean could be a bit above or below the confidence interval. It has nothing to do with the differences between the groups."

After consulting with other authorities in the field of psychotherapy research, I realized, that many others, who had accepted Smith's conclusions, probably had also done so on faith-engendered consensual validity, rather than a serious condisreration of the issues.

Nevertheless, in the true spirit of scientific inquiry, most of the researchers with whom I spoke were open to my questions, and graciously referred me on to other professionals who were more specialized in statistical analysis, when the could not explain the disparity.

This lead me to the Harvard-based statistical expert, Dr. Robert Rosenthal, Ph.D. (1994), who coined the familiar phrase *experimenter bias*. He explained that there **are** circumstances under which effect sizes can be as divergent as the numbers reported in the Smith & Glass meta-analysis (1980) and still not indicate significant differences between the categories. He did not know if the Smith meta-analysis was one of those occasions, however, and due to lack of time to explore the facts, neither he, nor other highly regarded professionals who were familiar with the much-discussed meta-analysis, were prepared to refute Eysenck's allegations about this study.

Finally, I was directed to Dr. Jacob Cohen, Ph.D., a professor emeritus of psychology at N.Y.U., who had reviewed the Smith & Glass meta-analysis in question in 1981. He *was* prepared to address himself to the disparity between data and conclusions. After refamiliarizing himself with the meta-analysis, he explained, in short order, that the large differences in some of the effect sizes of the 18 treatment methods were equalized through a statistical procedure called *regression analysis*, which was used to correct for *reactivity* (1994). "The regression analysis was used to correct for reactivity with the result that the (uncontrolled) apparent superiority of Behavioral over Verbal therapy classes disappears (i.e., Behavioral therapies used sufficiently more reactive outcome measures so as to account for the observed difference." ( Cohen, 1981)

**What is Reactivity and Why Should We Correct for It?**

According to Smith, et. al. "Virtually all methodologists, reviewers, and critics of psychotherapy research devote much attention to the factors and conditions that interact with therapy, since they may produce varying results. It is widely accepted, for example, that neurotics are easier to influence than psychotics or drug addicts and that experienced therapists are more effective than inexperienced therapists." (p.99) The widely differing effect sizes reported in the Smith study were mixed together with all other conditions that might interact with therapeutic effects. The reported differences between verbal and behavioral therapies on measures of global adjustment reflect true differences as well as the differences that might really be attributable to differences in client diagnosis, client motivation for therapy, differences in clients' age, sex,

socioeconomic level, or in the measurements used by the researchers, just to name a few factors contributing to the final effect size.

These extra variables confound the assessment of actual differences in the treatment and the regression analysis is an attempt to subtract their effects from the final result. According to Cohen (1981), the method as used here is somewhat crude, but he feels that it is "unlikely (although possible) that a better controlled analysis...would alter the author's conclusion that evidence is lacking for a difference between major therapy classes...."

**Handicapping the Horse**
**How Does One Know How Much To Correct?**

Suppose young, attractive, verbal, intelligent and successful people get more out of therapy. Suppose again that we have a larger concentration of these categories of people in the Behavior Therapy treatment group. We then handicap them, so that they actually have to show a higher score (in relation to their control groups) than the other treatment groups do, in order to make up for the part of the result that is due to their being young, attractive and verbal, intelligent and successful. How much of this effect is interactive? What if brighter people tend to choose more effective treatments?

Eysenck responded (1994) as follows to this explanation for the judgement of equality of treatments, with widely differing effect sizes: "[Reactivity] is completely inadmissible [for this meta-analysis] as far as I'm concerned, because it makes assumptions that all

these effects are similar for different populations; for different diseases, for different methods, and that they add together, but they might multiply. We just have no idea how they interact.

Essentially the kind of thing they do is to look at all the data for young and old and they find, that the young do better by 10%. And because more young people are going to behavior therapy, they take 10% off that effect size. But of course, it doesn't follow, because young people might benefit most from psychoanalysis. We don't know. This assumes a very simple kind of interaction, but the essence is that we simply don't know how they interact."

On learning that the Smith group had used regression analysis to account for reactivity and thereby had eliminated the differences in treatment effects, Dr. Robert Rosenthal (1994) now confirmed Eysenck's opinion on this matter of reactivity. Therefore, if reactivity is the basis of Smith's conclusion, that all of their studied methods of therapy are equal (as their report indicates it is), both Rosenthal and Eysenck are united in their rejection of the Smith et. al. "equality-of-treatments" inference. Their analysis does not support such a conclusion. Amazingly, Rosenthal now theorizes that Glass, himself, the man who put forth the equality of method conclusion, would now agree with him!

**Meta Meta on the Wall, Who's the Fairest of Us All?**

On June 25, 1993 at an International Meeting of the Society for Psychotherapy Research (SPR) in Pittsburgh a meta-analysis debate broke out. Meta-analysis the now much explored and statistically complex means of putting many experiments into one proverbial pot and weighing the ingredients according to their contribution to the importance of the statistical stew has come a long way since its introduction by Smith, Glass and Miller in 1977. Meta-analyses are appearing at an accelerating rate, and now exist in the hundreds.

According to Drs. S.J. Rachman and G. T. Wilson (1980), "... the superior precision and objectivity that a statistical analysis such as meta-analysis, promises over a so-called "literary review" is more apparent than real. "Meta-analyses are subject to the biases of the meta-analyst," reported Dr. Luborsky (1993). The results of the meta-analysis are influenced by the choice of experiments that comprise the analysis. Drs. Grawe, and Svartberg both agree with Dr. Luborsky; all three have produced and presented meta-analyses. Their meta-analytic conclusions support their own differing theoretical orientations.

Both the selection of experiments included, and the shibboleth by which the therapeutic methods are enacted leave a great deal of room for interpretation. This is because psychotherapists, regardless of their particular persuasions, tend to talk about what they do in a way that corresponds more to their training and affiliative group than to what they actually do. It is a well known fact that experienced therapists perform more like each other across disciplines than they do when they are compared to therapists of all experience levels that are drawn exclusively from within their own

persuasion. According to Dr. Lester Luborsky (1993) meta-analysis bias is virtually impossible to correct.

**Are There No Cures?**

At the 1993 SPR meeting, Dr. Hans Strupp, a distinguished and relentless crusader for scientific truth who has devoted the last four decades of his life to understanding the processes of psychological change, approached the microphone. He stood before a formidable audience of his peers and cohorts. Sixty scientists waited to hear him pronounce, "There are no cures." Dr. Strupp is not a prototypical ivory tower scientist; he has been trained by Frieda Fromm-Reichmann and profoundly influenced by Freud. The poetry and mysteries of psychoanalysis have not escaped his notice.

Nor is SPR an ordinary professional group. The 300 or so scientist-practicioners that comprise this unique organization do not seem to be predominantly driven by insular competitions: They have distinguished themselves by their unstinting quest for truth, no matter how unsettling the results. Although guided by the rigor and objectivity of science, they still seem to care for each other as well as for the people whose fates they try to improve. In their presence at the Pittsburgh conference, I had the feeling that I was among the elite.

Dr. Strupp orchestrated the now-classic Vanderbilt I study which compared the psychotherapy results of patients treated by benign college professors with those

treated by seasoned professional psychotherapists. Both types of therapists worked with matched groups of depressed male college students, only to find that, in the main, the untrained "nice guys" did just as well as the experienced and well-regarded professionals. He felt that the researchers may have inadvertently stacked the decks against the professionals because the depressed male college students had more in common and therefore more to talk about with the college professors than with the professional psychotherapists. This "mistake" may prove to be a very useful clue that points to results discussed later in this *Report*.

At this SPR conference Strupp had news of the Vanderbilt II study to report. In this study, manuals were used to standardize the behavior of the professionals and thereby minimize individual differences in their performance. The Structural Analysis of Social Behavior model (SASB), a measure of interpersonal sensitivity, was used to measure each dyad of selected therapeutic segments. This is one example of process research whereby one can see what is happening between the client and the therapist with great accuracy. Using another reality check, a patient-rated "therapy report card," Dr. David Burns, M.D. (1993) reported that some therapists are surprised and upset to discover the negative effect that they are having on the client, and therefore may become reluctant to use such measures. Strupp found that SASB feedback can be constructive and tends to increase conformity to the procedures delineated in the manual. Still Strupp has not reported that even this reality-based learning has been demonstrated to increase therapeutic results. He did report, however, that positive therapeutic outcomes tend to diminish over time, because of the many changes in people's lives over the years. Long term therapeutic gains appear to be an elusive commodity.

**Healing Alliances: Are They the Penicillin of Psychotherapy?**

Professional eclecticism is on the rise. The common effective ingredients to all schools of psychotherapy are a legitimate area for study. Since the placebo group used to control for the effects of psychotherapy in experiments often entails many of these common ingredients such as increased hopefulness, or alliance in the case of a so-called "inert" meeting with another person, *the placebo has often been called a misnomer.* But the placebo which is comprised of the effective human ingredients available for solace may indeed be the generic penicillin for neurosis. Strupp's prior reference to having tipped the balance in favor of the professors who had more in common with the client-students than the professionals did in his Vanderbilt I study, is perhaps the point on which our report must pivot. Dr. Lorna Smith Benjamin, Ph.D., the originator of the aforementioned, internationally used SASB model, has devoted decades to the careful scrutiny of the actual process of human relationship. She has quoted, the late Harry Harlow--her major professor: "A lone monkey is a dead monkey." Relationships are vital to life.

At the meeting Dr. Ed Bordin, Ph.D. was commemorated in a moving memorial symposium for having devoted much of his professional work to the study of the therapeutic alliance. Drs. Luborsky, Strupp, and Benjamin, and other professional researchers reported being profoundly influenced by him. The focus of their work is the study of alliance. Bordin believed that the strength rather than the kind of working alliance would prove to be the major factor in change achieved through psychotherapy.

Healing alliance is naturally sought after by distressed individuals. Dr. Frank Riessman, Ph.D., Director of the National Self-help Clearing House, has pointed out that the benefit accrued to an individual through being understood is a powerful dimension of self-help mutual aid, because of the potential for experiential understanding. Many people on waiting lists for therapy who comprise placebo groups benefit from self-help groups or from other kindred spirits who rise to the occasion of their needs. Dr. Louis J. Medvene, Ph.D. has compiled significant evidence that various self-help groups have produced successful therapeutic outcomes.

If we ask the right questions such as "What can psychotherapists do to improve their effectiveness?" Interesting answers begin to reveal themselves.

**Eysenck on the Cake**

Eysenck, has appeared in the title of a profile in the *New Scientist* as "The psychologist They Most Love to Hate." Noticeably not a SPR member, he is essentially known or as it turns out, misknown, for purporting a belief to which he lays no claim—the belief that therapy does no good. This mistake began when professional journals failed to correct and instead perpetuated an erroneous interpretation of his analysis of the outcome studies done up to 1954. At that time he actually analyzed the existing data available to him and said that there was no proof that therapy does more than spontaneous recovery—the process of getting better naturally—which happens to two thirds of all people suffering from neurotic disorders, over time. He did not say that therapy

unequivocally did no good, the far stronger conclusion attributed to him, but only that there was no proof of its effectiveness.

Now in the apex of his career, he comes forth as a formidable presence in the ongoing quest for the holy grail of effective psychotherapy—the elusive cure. Amidst a field strewn with weak outcomes and compromised meta-analyses, Eysenck heralds dramatic therapeutic results: Therapy incontrovertibly extends life. But what kind of therapy, by whom and for whom and how? Ever hooked on testing hypotheses and looking for traits, Eysenck moves easily in the complex world of statistics and numbers. He has joined forces with a German psychologist and professor of oncology, Dr. Grossarth-Maticek who has devoted 3 decades of his life to the study of therapy. Eysenck describes him as a gifted clinician, a quality he does not attribute to himself.

Grossarth-Maticek and Eysenck began with over three thousand normal subjects and tested them for pathological personality traits. Those who are prone to get cancer (Type C) repress emotions, are unduly compliant and fail to adequately cope with stress and loss. The heart attack types (type A) are often angry, hostile and aggressive. Grossarth-Maticek's predictions proved to be on the mark; the cancer prone types got cancer more often than the others and the heart attack types got more heart attacks. All this at a very high level of statistical significance. The differences remain highly significant even when smoking, cholesterol level, and blood pressure were partialed out. The study is longitudinal—it took 15 years.

Next comes the dramatic result: The cancer and heart attack prone types were told that they could live longer if they developed less stressful coping strategies and acted more appropriately, and they did. Three forms of autonomy training were explored. Of the first group Grossarth-Maticek selected a small sample of 92 heart attack prone patients and 100 cancer prone patients and divided them into a therapy and control group so that he actually treated 96 people individually. The controls were matched on age, sex, and rough score on the personality inventory and allocated randomly.

Treatment was individual and sometimes in groups. Once the behavioral analysis and formation of individual goals had been accomplished, a variety of techniques were put forth by the therapist for discussion. In group therapy, another controlled selection of 245 individuals who met from 6 to 15 times were drawn into mutually supportive communication. Patients decided on techniques and took an active part in their treatment.

The third form of this therapy centered around a printed explanation of how to achieve emotional independence and a healthy personality which the therapists presented to 600 patients and discussed for a further 3-5 hours, suggesting specific applications of the principles of the statement to the individual's needs.

For this, Grossarth-Maticek advertised for students (not necessarily in psychology) to act as bibliotherapists. He intuitively selected 110 dedicated students who also collected the follow-up data on some 30,000 healthy people, and paid them a minimal wage, more like that of a data collector than a psychotherapist. Even when the money ran out, they were motivated by the importance of the experiment and kept on working.

Each patient spent about 3 hours with one of the students who indoctrinated them in the methodology of Novative Behavior Therapy (becoming more autonomous) and the original interview was with Grossarth-Maticek who worked on their plan to contradict their maladaptive behavior, making them more like normal types than cancer or heart attack prone types of people.

Grossarth-Maticek called this entire procedure Novative Behavior Therapy, but the most people never heard of such a thing—it's translated directly from German. And what did he do with all the long-term carefully analyzed behavior? Fortunately, he wrote it all out step by step. Some might call it a more familiar name, cognitive behavior therapy. But what's in a name? I asked Eysenck if someone else, doing the same thing that Grossarth-Maticek did would get the same results. "I don't know," he said, "it depends on the man, not just the method." "And Dr. Eysenck, couldn't *Novative Behavior Therapy* be called *Cognitive Behavior Therapy*, or maybe its also being played out under the rubric of psychodynamic therapy?" I asked. It might be, but he **is** only prepared to call Novative Behavior Therapy by the more accessible title, *Autonomy Training*. Even the name sounds therapeutic. But effective therapy by any name is still effective therapy—the proper focus of our attention.

When asked about the lack of integration of this study into SPR discussions, Dr. Benjamin, former SPR president, has pointed to the possibility that many prominent reachers may not have studied this experiment because this work is regarded as "belonging" to *Health Psychology*. Due to political loyalties and the sheer volume of available information, researchers tend to read in their own areas of specialty.

This is the age of accountability. ***We must study what works regardless of orientation. Look for substantiated results.*** Indeed, effective psychotherapy, studied without regard for sect or affiliation seems to be the most fruitful course for investigation.

**Does Practice Make Perfect?**

Apparently experience does not necessarily, or even generally make one a better therapist (Sutherland). This is, in part, because one may perpetuate one's mistakes and erroneous beliefs without the benefit of corrective feedback. Probably one gets better at holding on to patients (a skill that is rewarded), but that is hardly synonymous with alleviating symptoms. There is, however, evidence that experienced therapists do better with certain more difficult groups of patients such as drug addicts. (Luborsky, Najavits, Strupp).

Alliances to schools of thought and their attendant economic encumbrances, and the complex of defenses that become an intrinsic part of the professional psychotherapy establishment, generate a recalcitrant barrier to the free flow of hard-won research knowledge to practice. Frequently even researchers concentrate their reading to include the work of a coterie of peers, while important research data drawn from alien schools of thought are slow to be integrated into the work of one's member group.

**Meta-meta, Getting Better?**

Standing on the shoulders of the rapidly proliferating meta-analysts, Drs. Lipsey and Wilson have been the focus of attention in research circles with their introduction of yet another, even more sophisticated, method to evaluate psychotherapy results.

According to their recent, fine-tuned meta-analysis of 302 meta-analyses (not individual experiments), Drs. Lipsey and Wilson in *The American Psychologist* (Dec. 1993, p.1181-1209) report the following conclusions:

"...the current treatment research meta-analysis literature is too crude to permit a truly probing analysis if the potential biases in estimates of effect sizes...

...A high proportion [of analyzed treatment approaches] do prove at least moderately efficacious." (ibid, p. 1200) Specifically, they conclude that treatment effects relative to placebo controls are smaller, on average, than those estimated relative to no-treatment control conditions. What, then, is the average effect size of treatment compared to a placebo?

Using a statistical method called the binomial effect size display (BESD) which was devised by Rosenthal and Rubin, Lipsey & Wilson try to determine the average treatment effect of 156 meta-analyses, comprised of 9,400 treatment effectiveness studies, which in turn, involve over 1,000,000 individuals. They determine that almost everything works, and that the average intervention has an effect size of about one half a standard deviation. Not overwhelming, but real.

This new method is unique in several respects: It indirectly involves over one million subjects, encompassing diverse types of interventions, from psychological to educational; and the analysts sensitively test for and then cull out extraneous effects likely to inflate resuts in order to arrive at a relatively uncontaminated effect size. For example, they find that experiments with positive results are more likely to be published than those with negative outcomes, and subsequently they correct for this source of bias. Lipsey was not primarily interested in psychotherapy. Indeed, according to Lipsey and Wilson's study of a subset of 30 meta-analyses (chosen because that compared placebos, controls and treatment groups), the treated group is about 75% percent above an arbitrary mean, and 57% of the placebo group is above that mean, with the control group receiving no treatment set at 50%. The analysts caution that these results may not be generalizable because "rather few meta-analyses reported separate effect estimates for placebo controls, and the majority of those were in the area of mental health and thus do not extend to other treatment domains." In fact, they were often studies involving psychological interventions, such as a prep talk before an operation about coping skills, rather than full scale psychotherapy.

Eysenck (1994) reacts to this meta-meta analysis as follows: "[The Lipsey & Wilson meta-analysis] mixes up data from schools and from computer teaching and from psychotherapy and from all sorts of things. You just can't do that. You can't take an average of apples and mice and whales. It's utterly and completely meaningless.

What are these placebo studies made up of? Are they all psychotherapy? Do they have some of the other things? Lipsey doesn't tell us. We don't know what kind of placebo they were. Usually placebo studies are terrible. They consist of very little that is even believable to a stupid person. They may consist just of registering for a later type of treatment that will be given when the study is over. Or it may just constitute a 3 to 5 minute interview that doesn't deal with any symptomatology at all. Unless you know what the placebo is you can't even begin to discuss it. To average all different types of placebo treatment, some of which may be useful, some may not... The whole thing is meaningless."

Lipsey says that he is studying fruit, not apples and oranges. He goes on to explain that although the effectiveness of psychotherapy may not seem large, one's perspective changes when standards for medical research are used.

**Psychotherapy Is Better than Aspirin**

The authors point out that far less of an effect is often considered enough for the medical treatment of life-threatening disorders.

Dr. Robert Rosenthal, Ph.D.(1990) gave heart to researchers and practicioners, weary of having their results generalized and dismissed as weak, by pointing to the comparatively meager statistical effects which are generally regarded as significant results in the medical profession. He cites a special meeting held December 18, 1987 to end prematurely a randomized double blind experiment on the effects of aspirin on

reducing heart attacks (Steering Committee of the Physician's Health Study Research Group, 1988)."The reason for the termination of the experiment was that it had become clear that aspirin prevented heart attacks (and deaths from heart attacks) and it would be unethical to continue to give half of the physician research subjects a placebo." The magnitude of the effects on which this decision was based was 4%!

Of course, taking an aspirin requires far less investment than a protracted course of therapy. Still, Rosenthal's point is well made. By those standards, the success rates reported by Lipsey shine. Be that as it may, psychologists are not in the habit of forecasting such seemingly lack-luster results. And as we have seen there are also dramatically successful and even life-extending results to be found in the therapeutic research literature. Would we not do better to study success rather than be content with very little?

**The Mind-Body Connection: Fertile Ground for Unambiguous Results**

Another champion of the mind-body connection, Dr. Lester Luborsky, has reported that effective psychotherapy has repeatedly been shown to be good for your physical health as well as your mental health. According to his reports (1992 & 1994), there is evidence that patients who participate in therapy generally reduce their use of medical services, and in an analysis of five studies, outpatient costs decreased by 23%, but inpatient costs showed a 73% decrease! Because patients in psychotherapy have, or believe they have, fewer physical symptoms, they seek less medical attention. Are they actually healthier or do they just have a higher morale, experience less stress, and

therefore report fewer symptoms? Clearly, these effects combine to actually produce healthier people.

Stress effects our autoimmune systems. The physical benefits of good psychotherapy experiences can even be seen through a microscope: Luborsky (1992) reported that an immune system measure, the presence of Natural Killer cells in the blood, decreased in those who most benefited from therapy for depression.

As our mental states improve we tend to take better care of our bodies; we exercise more, take vitamins, and eat more sensibly. The mind and the body are inextricably connected. It is therefore not surprising that reducing stress through effective psychotherapy will be manifested in a healthier body, as well.

**Alliance: The Most Fruitful Predictor of Good Outcome**

Another neglected area which has produced disproportionately powerful results is psychotherapy by the paraprofessional. Dr. Bertram P. Karon, Ph.D. (1993) has suggested that this inequity may occur because of economic considerations.

Luborsky, Strupp, and other seasoned researchers find that alliance (as judged by the client) is the currently acknowledged most powerful force in effective psychotherapy. **If we increase the alliance, will we consequently increase the effect**? Dr Michael Lambert, Ph.D., who with Dr. Alan Bergin, Ph.D. has co-authored "The Effectiveness of Psychotherapy," a chapter in *The Handbook of Psychotherapy and Behavior Change*

agrees with the author's conjecture, as does Luborsky. We will. In the surprisingly neglected, but remarkable Janus studies (discussed in the *1993 Update*) the powerful effect of increased alliance has already been demonstrated in a cost effective manner.

In a time of increasing accountability, the outcome of psychotherapy research must make its complex findings public so that quick fixes and unsubstantiated cures don't replace the more arduous and enduring therapeutic alliances that are the solid structure on which various methods of treatment guide the wistful client to more satisfying responses to life's trials. We must use this hard won knowledge and study success—wherever it occurs—rather than elusive hypothetical constructs. We must look at the man or woman more than the method, an area of study recently reported on by Dr. Lisa Najavits, Ph.D. (1994) which does yield significant differences. Researchers too must increase their alliances and thereby increase their effect.

**Redirecting the Search**

If we shine the search lights of our investigation on the much-neglected area of individual differences in therapist abilities we will find effects that are far more impressive, and probably as different as the relative performances of salespeople, actors, clergymen, nurses or professors. Salespeople universally tend to follow a rule of thumb, twenty percent of the sales force make eighty percent of the sales. In a sense, the therapist is selling a better coping strategy to the patient. This requires that he relate well, and talk a language that the client will understand and also come equipped with life skills or methods that work. The client must trust the therapist's

intention in order to internalize his or her message. Are therapists like salesmen born and not made?

Distinguished and diverse experts, such as Hans Eysenck, Jerome Frank, Lester Luborsky and Hans Strupp, who have devoted a lifetime to research in the psychotherapy arena, but have come to similar conclusions. Except for very specific disorders such as tics, phobias or bedwetting for which behavioral treatments are superior, who the therapist is, is more important than the treatment method.

If such luminaries who have devoted their professional lives to the exploration of what works in psychotherapy intuitively agree that the men or women engaged in therapy are more potent predictors of outcome than method alone, why has so little attention been devoted to individual therapists as predictors of outcome?

There is an obvious difficulty and unpleasantness associated with such comparisons. It is easier to ascertain which therapist has the greatest caseload or the highest income or most research citations, but how does one judge who is helping whom, and how much? Barring its inherent obstacles, such research is not without fruitful precedent.

**In Chinese crisis means opportunity**

The profession of psychotherapy is under unprecedented scrutiny. Recently the Federal Government stopped authorizing reimbursement for psychoanalysis, once the bastion of sacred treatments, because there is no evidence that it works. The trend is one of accelerating accountability and scrutiny.

How can professionals increase the vital dose of therapeutic alliance within the economic structures in which we are all confined? Increase patient feedback, increase ease of patient referral, increase the practice of appropriate patient pairing, and open the doors to let the wisdom of research and the wisdom of successful therapeutic practice enrich each other. Study success wherever it occurs, without regard for restrictive denominations and immediate economic considerations. If documented therapeutic effectiveness is increased by pairing patients and thereby increasing their sense of alliance in a cost-effective manner, appropriate compensatory systems will follow. *Audaces fortuna iuvat.* Fortune favors the the bold.

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## Roberta Russell

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After working as an electronic data processing consultant/systems analyst she founded and ran R.R. Latin Associates Inc., a New York based search firm specializing in computer professionals, from 1970 until 1987. She was a board member of the European Association of Humanistic Psychology (Geneva, Switzerland), the Education and Accreditation Committee of the National Accreditation Association and American Examining Board of Psychoanalysis, Inc. and of Women Business Owners of New York. Ms. Russell has lectured at Oxford University (U.K.), Yale University, The New School for Social Research, New York University, North Country' Community College, The University of Glasgow (Scotland), Sophia University of Rome and the Third Italian Congress of Humanistic Psychology and in universities across New Zealand and Australia. She was also a featured speaker at the International Conference on Psychotherapy of the Future, in Spain and the Healthier Living Show in Australia, the Australian Psychological Society and the New York Public Library.

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# Only Psychiatrists Can Treat Mind and Body

To the Editor:

There are two erroneous claims in Gertrude Blanck's letter of Dec. 8 [on social workers as psychotherapists]. The first is merely misleading; the second, if taken literally, is potentially dangerous.

Miss Blanck implies that psychologists, psychiatrists and social workers, "if they are to become competent psychotherapists," must have rigorous training at a psychotherapy or psychoanalytic institute, including personal psychoanalysis. In fact, there is little evidence to support this claim. As a recent legislative report on effective psychotherapy prepared by Roberta Russell for a public hearing of the New York State Assembly Committee on Higher Education makes clear, neither traditional psychoanalytic training nor a personal analysis is associated with psychotherapeutic competence.

Miss Blanck goes on to claim that, upon completion of this "rigorous training," "there is no difference between a psychotherapist who was a social worker and one who was a psychologist or a psychiatrist."

If Miss Blanck wants to claim that social workers, psychologists and psychiatrists are generally *as efficacious* as psychotherapists, there is some data to support her. This is a far cry from saying that there is "no difference" between psychiatrists and other mental health professionals.

Only the psychiatrist is qualified to evaluate and treat *both* physical and psychological complaints. Unfortunately, there is no easy way to sort out these frequently interrelated problems, and non-physicians are unqualified to do so.

I trust that Miss Blanck is as alarmed as I am that social workers — indeed, social work *students* — often make medical and pharmacological decisions at some community mental health centers. A study by E. K. Koranyi published in the Canadian Psychiatric Association Journal (1972) shows that nearly 10 percent of a psychiatric outpatient population may suffer from "mental" problems due directly to underlying physical illness. Yet it is the psychiatric outpatient who is often seen by the paraprofessional or nonphysician.

As to Miss Blanck's gratuitous claim that medical training is a "detour" on the road to effective therapy and that social workers are the better for having missed it, I should like to see the evidence. In the meantime, the public should know that among mental-health professionals, only the psychiatrist is trained to deal with the interface between mind and body.

RONALD PIES, M.D.
Senior Chief Resident in Psychiatry
State University of New York
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Syracuse, Dec. 8, 1981

# Is Your Psychotherapy Technique Effective?

**"The academic training of psychotherapists does not assure or even correlate with practitioner competence."**

That's a statement from Roberta Russell's book REPORT ON EFFECTIVE PSYCHOTHERAPY: LEGISLATIVE TESTIMONY.

The book is an action-oriented workbook. It has been designed:

- To provide a concise, up-to-date summary of research studies which identify the "active ingredient" in effective psychotherapeutic treatment

and

- To provide motivation and direction for change in the human interface systems and the government regulations currently operating in the psychotherapeutic community.

The REPORT is structured to address six pertinent—and quite controversial—research conclusions, which are backed up with abundant supporting data.

1. Studies show that the outcome of psychotherapy does not depend upon the school to which the therapist adheres.
2. The common denominator of experience makes experienced therapists resemble each other to a greater extent than they resemble less experienced therapists within their respective disciplines.
3. In short-term studies paraprofessionals consistently achieve outcomes equal to or better than those of professionals.
4. A personal training therapy does not appear to increase the effectiveness of the therapist.
5. Therapists who have undergone traditional training are no more effective than those who have not.
6. Congruent matching of therapist and patient increases the effectiveness of therapy.

The methodology used in the REPORT combines traditional and innovative techniques. The conclusions are based on a general review of the therapy outcome literature and in-depth examination of exemplary studies, which are detailed in the bibliography. Of particular interest to some will be the "anthropological research," provocative interviews with such psychotherapists as Arnold Lazarus, Irving Weinstein, Robert Carkhuff, Alan Towbin, Daniel Hogan, and Hans Strupp, which verify and clarify the findings.

The REPORT has become more than a research paper. It has become a political

(Please Turn Over)

statement as well. The concluding section is a workbook which challenges the reader to draw upon the research to action-plan new directions for the future.

The author's recommendations are presented in the legislative testimony delivered before the Higher Education Committee of the New York State Assembly.

Prior to presentation before that body, the REPORT was well received at professional conferences in Geneva, Switzerland; Zaragosa, Spain; and Rome, Italy. The document has also been incorporated in a proposal by the National Center for the Study of the Professions in Washington. It earned its author a place on the Board of the European Association of Humanistic Psychology.

The author is also a member of the Board of the National Accreditation Association and American Examining Board of Psychoanalysis, Inc., and is on the Steering Committee of the American Council for Human Service, Inc.

The REPORT is bound to stir controversy. It grapples with the question of how the consumer should choose a therapist. According to the REPORT:

> "The fact is that consumers of mental health services choose therapists on the basis of their credentials and licenses granted by government, but neither credentials nor licenses bear any relation to patient improvement."

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